

GRIEF COUNSELING FOR ADULT PET LOSS: A PRIMER  
FOR MENTAL HEALTH PROFESSIONALS

by

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**Abstract**

Grief counseling receives minimal attention in mental health training programs. Many mental health professionals are unprepared to support adult clients with pet loss and the associated bereavement process. Pets fill many vital roles in the lives of adults and the loss of a pet can be a profound experience. Adults sometimes develop intense attachment bonds with pets, and the quality of the human-pet attachment may influence the grief resolution process. Bereaved individuals may experience complicated grief reactions, including co-occurring mental health disorders. Understanding key clinical issues associated with pet loss can both help clinicians provide appropriate client support and facilitate positive treatment outcomes. As an outcome to this research, an educational webinar highlighting key findings gained from the literature review has been developed to assist clinicians with adults whose presenting concerns relate to pet loss.

*Keywords:* attachment bonds, bereavement, complicated grief, disenfranchised loss, grief, grief counseling, grief education, grief models, human-animal bonds, loss, pet loss

**Table of Contents**

	Page
Abstract.....	ii
Table of Contents.....	iii
Grief Counseling for Adult Pet Loss: A Primer for Mental Health Professionals.....	1
An Overview of Grief Counseling.....	6
Definition of Terms.....	7
Attachment Theory and Grief.....	8
Components of Grief .....	12
Physical.....	12
Cognitive.....	13
Emotional .....	13
Social.....	14
Spiritual.....	14
Grief Theories and Models .....	14
Kübler-Ross .....	15
Rando .....	15
Freud .....	16
Lindemann .....	17
Parkes and Weiss .....	18
Bowlby .....	18
Worden.....	19
Ströebe and Schut .....	20
Klass.....	20

Neimeyer.....	20
Grief Variables.....	22
Understanding Complicated Grief.....	23
Clinical Grief Assessment in the DSM.....	25
History of clinical grief diagnosis.....	26
Current standards for clinical grief diagnosis.....	27
Persistent complex bereavement disorder.....	28
Differential diagnosis.....	29
Assessment Instruments.....	32
Grief Interventions.....	33
Uncomplicated grief.....	33
Grief techniques.....	34
Counselor self-awareness.....	35
Complicated grief.....	35
Interpersonal therapy (IPT).....	36
Cognitive-behavioral therapy (CBT).....	36
Pet Loss Counseling.....	39
Human-Pet Relationships.....	40
Components of Pet Loss.....	43
Pet Loss Models.....	44
Essential Factors of Pet Loss.....	45
Attachment bonds with pets.....	45
Disenfranchised grief.....	48



Circumstances of pet loss.....	50
Complicated Pet Loss .....	52
Pet Loss Assessment Instruments .....	55
Interviewing the Bereaved Pet Owner .....	56
Pet Loss Support Model.....	57
Pet Loss Interventions.....	58
Intended Audience .....	64
Application.....	65
Conclusion .....	66
References.....	69
List of Appendices .....	87
Appendix A: Application.....	90
Appendix B: <i>Proposed Diagnostic Criteria for Persistent Complex Bereavement Disorder</i> .....	190

### Grief Counseling for Adult Pet Loss: A Primer for Mental Health Professionals

Counseling preparation programs typically fail to provide adequate training in the area of grief counseling (Doughty-Horn, Crews, & Harrawood, 2013; Pomeroy & Garcia, 2009). More specifically, the Council for Accreditation of Counseling and Related Educational Programs (CACREP), the primary accreditation board for counseling education programs in the U.S. (Wilkinson, 2014), does not include grief education in its explicit curricular requirements for counseling training programs (CACREP, 2015; Doughty-Horn et al., 2013). As such, it is not surprising that many counseling trainees and licensed mental health professionals feel unprepared to deal with the clinical issues associated with either human or pet bereavement (Cicchetti, 2010; Doughty-Horn et al., 2013).

Given that death and the associated bereavement process are universal human experiences (Chan & Tin, 2012; Clark, 2004; Fox & Jones, 2013; Hooyman & Kramer, 2006; Pomeroy & Garcia, 2009), mental health professionals should anticipate the need to provide bereavement support to clients (Chan & Tin, 2012; Doughty, Wissel, & Glorfield, 2011; Hooyman & Kramer, 2006). Moreover, since the ACA Code of Ethics (ACA, 2014) mandates that counselors work within the parameters of their educational training and professional competence (Standard C.2.a), the availability of resources that educate mental health professionals on how to best support clients through the pet bereavement process is crucial.

Grief can be a particularly devastating experience, one that significantly impacts an individual's ability to function across multiple life dimensions: physical, cognitive, emotional, social, and spiritual (Cicchetti, 2010; Mallon, 2008; Pomeroy & Garcia, 2009). Moreover, the pain associated with bereavement is often disabling and profound (Shear & Mulhare, 2008). Although most individuals are capable of processing and integrating this type of loss without

clinical intervention (Neimeyer & Currier, 2009), others experience a protracted period of severe, unresolved grief, which the literature most frequently refers to as complicated grief (Boelen, 2006; Daneker & Aiello, 2015). In working with bereaved clients, mental health professionals need to know how to distinguish a normal, uncomplicated grief response from a complicated one (Boelen & van den Bout, 2008). Further, in order to facilitate an understanding of complicated grief, clinicians should be familiar with the primary complicating factors (Jeffreys, 2005) as well as the associated risk factors (Chiu et al., 2010; Goldsmith, Morrison, Vanderwerker, & Prigerson, 2008; Laurie & Neimeyer, 2008).

The literature suggests that individuals process the experiences of human bereavement and pet bereavement very similarly (Alstat, 1997; Archer & Winchester, 1994; Bobier, 2011; Clements, Benasutti, & Carmone, 2003), and that the grief associated with the loss of a pet can be equal to or greater than the intensity associated with the loss of a person (Carmack, 1991). Moreover, the experience of losing a pet could be among the most significant losses people experience in their lifetimes (Butler & DeGraff, 1996; Watt-Aldredge, 2005). Unfortunately, many helping professionals tend to minimize or pathologize human-pet attachment bonds (Brown, 2006; Turner, 2003), and suggest that such bonds are inferior to those experienced in interpersonal human relationships (Morley & Fook, 2005). Given this attitude, many mental health professionals may not fully comprehend the repercussions associated with losing an animal companion (Brown, 2006; Gage & Holcolm, 1991). This lack of understanding may explain why so few professional training resources are offered for pet loss support (Clements et al., 2003), and why many professional helpers are unprepared to counsel individuals experiencing this type of loss (Sharkin & Bahrack, 1990).

With the numerous vital roles that pets play in our lives, and the thousands of American adults who experience pet loss every year, it seems essential that mental health professionals have a basic understanding of the core issues associated with pet bereavement (Beder, 2013). Moreover, given the deficits in counseling preparation programs related to the general topic of grief counseling (Doughty-Horn et al., 2013), and the more specific issue of pet loss counseling (Sharkin & Bahrnick, 1990; Sharkin & Knox, 2003), it seems critical to bridge this training gap by providing counselors and other mental health professionals with information that helps them both understand the profound sense of loss an individual might experience following a companion animal's death, and prepares them to respond in an appropriate and compassionate manner (Donohue, 2005). To that end, this paper explores the following research question: "What do mental health professionals need to know in order to competently assess and treat issues associated with adult pet loss?"

To answer this question, a comprehensive literature review was conducted that examined the history of grief counseling, including theoretical orientations, grief factors, how to distinguish normal grief reactions from pathological ones, how to assess for co-morbid psychological disorders, and evidence-based intervention models and methods. The literature review further examined grief counseling in the context of adult pet loss. As the validity of Bowlby's attachment theory as a model for human-pet relationships has been established in the literature (Zilcha-Mano, Mikulincer, & Shaver, 2012), and since the impact of attachment bonds between humans and their pets was widely discussed in the literature (Archer & Ireland, 2001; Archer & Winchester, 1994; Beder, 2013; Brown, 2006; Brown, Richards, & Wilson, 2001; Margolies, 1999; McCutcheon & Fleming, 2002), particularly with regards to how these bonds can significantly influence the grief response in pet bereavement (Archer & Winchester, 1994),

Bowlby's attachment theory was utilized as the overarching theoretical framework guiding the discussion of the research question.

In brief, Bowlby's attachment theory posits that human infants form attachment bonds with parents or other essential caregivers as a part of a larger security-seeking process, and that any disruption in these bonds creates feelings of distress and elicits behaviors from the infant intended to re-establish the disrupted connection (Hetherington, Parke, Gauvain, & Locke, 2006; Pomeroy & Garcia, 2009; Santrock, 2009). As adults, these same types of innate attachment instincts motivate individuals to form and maintain relational bonds with others, and to seek support through these bonds during times of distress (Archer & Ireland, 2011; Shear & Mulhare, 2008). The literature further indicated that individuals who develop strong pet attachments often have intense grief responses when those bonds are broken (Zilcha-Mano et al., 2012).

Whereas some individuals consider it essential for counseling education programs to include grief counseling as an explicit element in their training programs (Cicchetti, 2010), the lack of explicit curricular inclusion for grief training may prevent many mental health professionals from acquiring the requisite experience and tools needed to provide appropriate grief services to clients (Cicchetti, 2010). As such, based on the findings presented in this paper, an educational webinar has been developed to address this training need and to provide an expanded dissemination of the key concepts presented herein. The content of the webinar was distilled from this paper, and it outlines issues associated with providing grief support to adult clients experiencing pet loss. In particular, the webinar discussed a variety of elements pertinent to pet loss among adults, examined the relevant clinical issues associated with pet loss, and presented intervention strategies for assisting mental health professionals in providing appropriate grief support services for adult pet loss.

The intended audience for the findings of this research project is mental health professionals, including licensed professional counselors, marriage and family therapists, psychologists, and social workers. Considering the profound feelings of loss associated with the ending of an important relationship, or the death of a loved one (Heikkinen, 1979), and given the importance of pets in the lives of many individuals and families (Brown, 2006; Cavanaugh, Leonard, & Scammon, 2008; Podrazik, Shackford, Becker, & Heckert, 2000), this comprehensive literature review makes the case that mental health professionals should be prepared to address commonly occurring grief factors in adult populations, particularly those related to adult pet loss. Specifically, the culmination of key findings from the literature reviewed suggests that professional training for pet loss should be designed to increase the counselor's sensitivity to the needs of clients dealing with this particular type of loss and to prepare counselors to provide appropriate clinical support and interventions (Krause-Parello, 2012).

In sum, the literature confirmed a need for mental health preparation for both grief counseling (Cicchetti, 2010) and adult pet loss (Turner, 2003). As such, the literature associated with grief counseling for adult pet loss was examined and distilled into two distinct areas of investigation. First, the literature review focuses on clinical elements concerning the broader topic of grief and bereavement counseling. To begin with, this portion of the literature review outlines the role of attachment in loss and bereavement, the components of grief, grief theories and models, and primary grief variables. Next, the findings describe the presentation of complicated grief, including key complicating factors and identified risk factors. In particular, the American Psychiatric Association's (2013) *Diagnostic and Statistical Manual of Mental Disorders* (DSM-V) addresses grief complications associated with comorbid mental health

issues. The next segment of this portion of the literature review highlights assessment instruments that can be used to measure factors associated with complicated grief and adult attachment. The final segment discusses grief interventions, including counseling skills and techniques, the importance of counselor self-awareness in the context of grief counseling, and a brief introduction to proven intervention strategies that address complicated grief issues associated with human loss.

After examining the general issues of grief work, the literature review details grief counseling in the specific realm of adult pet loss. This portion of the literature review begins with a discussion of the importance of pets in our lives, the essential roles that pets play, and the nature of human-animal relationships. Next, the findings describe models of pet loss, components of pet loss, pet loss assessment, and essential pet loss factors. Then, the literature presents findings associated with complicated grief in the context of pet loss and identifies instruments for measuring targeted pet loss factors. The last section of this portion of the literature review highlights findings related to pet loss interventions. Finally, in order to address the need identified in the research question, a practical application piece was developed to educate mental health professionals about these key findings.

### **An Overview of Grief Counseling**

Counseling for grief, loss, and bereavement is a vast subfield within the counseling profession. As such, specific concepts and terms exist within this subfield to help guide the efforts of behavioral healthcare providers offering services to clients presenting with these concerns. In order to provide the necessary context for understanding grief experiences associated with pet loss, essential terms within this subfield are introduced and defined below.

### Definition of Terms

The following key terms guided the discussion of the literature. When companion animals were referred to in the literature on human-animal bonds, the term *pet* was primarily indicative of a pet dog or cat (Chur-Hansen, 2010). *Grief* was identified as “(a) an emotion, generated by an experience of loss and characterized by sorrow and/or distress, and (b) the personal and interpersonal experience of loss” (Humphrey, 2009, p. 5). Grieving was further characterized as “the process of separating ourselves from losses so that we can survive, effect necessary life changes, and foster new attachments” (Heikkinen, 1979, p. 46). Finally, the term, *grief*, was used to describe the internal processes (cognitions and emotions) and external responses (behaviors) that are activated when an individual either experiences or anticipates a loss (Jeffreys, 2005). *Loss* was identified as “the real or perceived deprivation of something deemed meaningful” (Humphrey, 2009, p. 5). *Bereavement* was broadly defined as “a period of sorrow following the death of a significant other” (Humphrey, 2009, p. 6), while the clinical definition of bereavement featured in the DSM-V was described as “the state of having lost through death someone with whom one has had a close relationship” (American Psychiatric Association, 2013, p. 818). *Mourning* was identified as “socially prescribed practices or outward expressions of grief” (Humphrey, 2009, p. 6). It is important to note that bereavement is always death-related, while mourning may be non-death related (Humphrey, 2009).

The majority of bereaved individuals experience a normative response to a traumatic loss (Zhang, El-Jawahri, & Prigerson, 2006). However, for some individuals, the pain of bereavement can have a profoundly detrimental impact on their lives (Shear & Mulhare, 2008), such that they experience an ongoing struggle to accept the loss and move on (Hensley, 2006). As such, a primary clinical concern in grief assessment is the need to determine whether the



client's grief response falls within the parameters of what is considered normal or what is considered pathological (Boelen & van den Bout, 2008).

A normative bereavement experience, also referred to as an uncomplicated grief response, typically occurs within a six-month time frame. The resolution of grief is associated with an individual's ability to complete the following key grieving tasks: to reach some degree of acceptance regarding the loss, to engage in professional activities, to imagine the potential for developing new relationships, and to experience positive emotions (Zhang et al., 2006).

Conversely, the term, *complicated grief*, is used to describe a non-normative grief response, where both the intensity and duration of symptoms exceed expected norms (Botella, Osma, Palacios, Guillen, & Baños, 2008), and the experience of grief interferes with the client's ability to feel a sense of resolution regarding the loss (Boelen & Prigerson, 2007). More specifically, complicated grief occurs when "acute grief is prolonged indefinitely, accompanied by complicating thoughts, behaviors, and dysfunctional emotion regulation" (Shear & Mulhare, 2008, p. 663). A key clinical distinction of complicated grief is that it typically requires some type of psychiatric intervention in order to reach a successful resolution (McNicholas & Collis, 1995). Numerous terms are used in the literature to describe maladaptive grief responses, including abnormal grief, atypical grief, pathologic grief, traumatic grief, and complicated bereavement (Zhang et al., 2006). More recently, the terms, prolonged grief disorder and persistent complex grief disorder, have been used to describe complicated grief in a diagnostic context (Boelen & Prigerson, 2007).

### **Attachment Theory and Grief**

Bowlby's attachment theory described social development in terms of interpersonal relationship bonds, particularly early parental bonds, and their influences on an individual's

perception of being secure, particularly in stressful circumstances (Ravitz, Maunder, Hunter, Sthankiya, & Lancee, 2010). These attachment patterns have proven consistent across many Western cultures (Hetherington et al., 2006). Bowlby's theory of attachment has been widely used in the literature to explain both the nature of the relationship and the strength of the relational ties between the bereaved and the lost loved one (Archer & Ireland, 2011; Kominsky & Jordan, 2016). In addition, attachment theory has been used as a model for examining the impact of human-pet relational bonds on the grief process (Archer & Ireland, 2011).

The comfort that comes from contact with another human being, and the feelings associated with trusting that a significant other will be there when needed, are core human needs (Young, 2008). As such, the initial attachment that develops between an infant and their caregiver is considered a notable aspect of child development (Hetherington et al., 2006). Further, the process of attachment does not end in infancy; as children age, they start to form relational attachments to peers, siblings, and other family members, while as adolescents, they begin to form attachments with romantic partners (Hetherington et al., 2006).

Some individuals form a strong, initial bond with their primary caregiver, establishing them as a reliable source for both personal affirmation and relief from distress (Santrock, 2009). In this type of consistent, interpersonal relationship, the child perceives the caregiver as a *secure base* from which to explore both themselves and the world around them (Santrock, 2009), as well as a *safe haven*, a provider of protection, assistance, and reassurance, when facing a crisis or experiencing other types of distress (Zilcha-Mano et al., 2012). Further, the development of a secure attachment bond is predicated on the ability of the attachment figure to act as both a secure base and a safe haven (Zilcha-Mano et al., 2012). Overall, a secure attachment

experience fosters a sense of security and promotes feelings of self-confidence in the child (Santrock, 2009).

Developing a secure attachment bond as a baby creates a healthy foundation for an individual's future social and emotional development (Hetherington et al., 2006; Santrock, 2009), as the initial attachment process informs how a child processes emotional data and learns to conceptualize and regulate emotions (Hetherington et al., 2006). In addition, adolescents with early, secure attachment profiles are more likely to form close friendships with peers, to sustain romantic partnerships for longer periods of time, and to have a greater sense of self-confidence (Hetherington et al., 2006).

Although some infants develop secure attachments to their caregivers, others form one of three types of insecure attachments: (a) *insecure avoidant*, b) *insecure anxious*, and c) *insecure disorganized* (Kominsky & Jordan, 2016; Santrock, 2009). Infants who developed the insecure avoidant style of attachment typically had caregivers who were more rejecting or unavailable, who provided limited physical contact with the baby, and who frequently failed to respond to the baby's signals; these infants displayed their sense of insecurity by avoiding the caregivers (Santrock, 2009). Infants with the insecure anxious style had caregivers who were not particularly affectionate towards them, and who were inconsistent in responding to their needs; these infants vacillated between pushing the caregiver away and clinging to them (Santrock, 2009). Infants with the insecure disorganized style had caregivers who frequently abused or neglected them; these infants showed more significant displays of resistance and avoidance towards caregivers, and sometimes appeared to be intensely fearful in the presence of caregivers (Santrock, 2009).

These early bonding patterns discussed by Bowlby and Ainsworth, have proven stable into adulthood, and have been shown to influence many key domains including coping ability, response to stress, social functioning, and psychological well-being (Hetherington et al., 2006; Ravitz et al., 2010; Santrock, 2009). Moreover, individuals with insecure attachment styles may find it more difficult to trust in social relationships and to develop mature, emotional bonds with others later in life (Hetherington et al., 2006). For example, insecure-avoidant adults often avoid intimacy and maintain emotional distance with others (Jeffreys, 2005), whereas insecure-anxious adults often have a deep fear of abandonment that leads them to be controlling, possessive, and clingy with significant others (Jeffreys, 2005). Insecure-anxious adults are also likely to worry that their attachment figures are not dependable for support and safety (Jeffreys, 2005).

Bowlby asserted that attachment theory could also be applied to adults to explain the emotional upset and distress experienced by individuals when significant attachment bonds were disrupted (Humphrey & Zimpfer, 2008). Moreover, an individual's attachment style significantly informed how they responded to loss (Kosminsky & Jordan, 2016). For example, adult individuals with an avoidant attachment style were more likely to minimize the importance of relational bonds, and to focus on being self-reliant while avoiding intimacy with others (Ravitz et al., 2010), while adult individuals with an anxious attachment style were more likely to hyper-focus on the availability of attachment figures and to anticipate experiences of abandonment and separation. Compared to individuals with a secure attachment style, insecure-anxious adults are at greater risk for grief complications as a result of their common incapacity to change the way they connect to lost attachment figures (Jeffreys, 2005).

Overall, mental health professionals should remember that attachment is an instinctive developmental response that begins in infancy and continues into adulthood with the primary

purpose of protecting the individual from danger and distress (Jeffreys, 2005). These bond patterns continue to inform how individuals relate to significant others in adulthood (Jeffreys, 2005). Moreover, when an attachment bond is severed through permanent separation or death, an individual's natural response is to grieve the lost connection (Jeffreys, 2005).

In review, the exploration of the impact of attachment bonds on the experience of grief yielded several key findings. Attachment patterns inform the nature of the relationship as well as the strength of relational ties between a bereaved individual and their lost loved one. As such, attachment theory has been widely utilized to explore the impact of human-pet relational bonds on the bereavement process. Although attachment bonds are initially established in infancy, these bonds persist into adulthood and influence an individual's capacity for coping with and responding to stress, functioning in social situations, and overall psychological well-being. As such, when loss disrupts these relational bonds in adulthood, individuals experience distress. Although the ways in which adults respond to the separation distress of loss are informed by the nature of their attachment bonds, their expressions of grief can manifest in numerous ways.

### **Components of Grief**

The experience of grief is comprehensive, and it impacts individuals across many levels, including physical, cognitive, emotional, social, and spiritual (Jeffreys, 2005; Worden, 2002). Although individuals will experience certain types of symptoms more than others, counselors should be alert to the following types of normal grief responses (Jeffreys, 2005).

**Physical.** The process of bereavement impacts various aspects of an individual's physical being, including the exacerbation of existing physical complaints and depression of the immune system (Jeffreys, 2005). Specifically, grief is associated with stomach pain and nausea, changes in both appetite and weight, dry throat, chest pain, shortness of breath, dizziness, sleep

disturbances, low energy, muscle aches, increased colds, and a lack of sexual desire (Jeffreys, 2005).

**Cognitive.** The inconsistency that individuals experience in comparing their pre-loss existence with their post-loss reality can be mentally disorienting and fatiguing (Jeffreys, 2005). Specifically, grief is associated with difficulty concentrating, memory loss, confusion, slow response times, loss of interest in participating in activities, perceived helplessness and futility, and an uncertainty about their post-loss identity (Jeffreys, 2005).

**Emotional.** Several key emotions are commonly associated with grief, including sadness, anger, fear, guilt, and shame (Jeffreys, 2005). Sadness may be expressed in a variety of ways, including crying, verbalization of hurt, head shaking, hand wringing, and sighing (Jeffreys, 2005). The sadness that comes with grief may be experienced in waves of feeling that are unpredictable and may cause an individual to experience both bad days and not so bad days, without any predictable pattern (Jeffreys, 2005). The anger associated with grief can be intense, and may be expressed via verbal outbursts or physical expressions, such as door slamming or fist banging (Jeffreys, 2005). Counselors should be prepared for clients to direct grief-related anger towards them as a means of exploring whether the space is truly safe for expressing their pain (Jeffreys, 2005). Fear is another common grief experience, particularly as it relates to life without the lost other (Jeffreys, 2005). For example, individuals may be afraid of being alone or of not being able to cope on their own (Jeffreys, 2005). Guilt is another common affective issue associated with grief, particularly when the individual feels a sense of responsibility for the loss (Jeffreys, 2005). The shame associated with grief is informed by the individual's perception of how others react to their loss; this social-based feeling of shame leads many individuals to withdraw from their typical support networks and isolate themselves (Jeffreys, 2005).

**Social.** People react to grief in different ways, with some avoiding bereaved individuals, and some offering unsolicited advice; others may unintentionally cause harm with inappropriate or distressing comments (Jeffreys, 2005). Individuals experiencing the loss may be particularly hurt when friends and family do not acknowledge or offer support in their time of need (Jeffreys, 2005).

**Spiritual.** It is very common for bereaved individuals to turn to religious and faith-based belief systems to help understand or provide a larger context for their loss (Evans, 1997; Jeffreys, 2005). However, the experience of grief may cause other individuals to question their beliefs or spiritual worldviews (Jeffreys, 2005).

This section presented key findings associated with what mental health professionals need to know about the presenting issues associated with grief. In particular, the experience of bereavement impacts individuals across multiple life domains, including physical, cognitive, emotional, social, and spiritual. Within each of these domains, grief may manifest in numerous specific ways, but the particular constellation of grief components experienced by bereaved individuals is not predictable. In addition to understanding the components of the grief experience, mental health professionals should also be acquainted with a range of grief frameworks in order to better understand how individuals potentially navigate the bereavement process (Podrazik et al., 2000).

### **Grief Theories and Models**

As there is no single method of grief counseling that practitioners universally agree upon (Altmaier, 2011), this introduction to grief theory focused on models that were prominent in the literature on both human and pet bereavement. Specifically, this literature is based on identified theoretical constructs of grief by Elizabeth Kübler-Ross, Therese Rando, Sigmund Freud, Erich

Lindemann, Colin Murray Parkes and Robert Weiss, John Bowlby, William Worden, Margaret Ströebe and Henk Schut, Dennis Klass, and Robert Neimeyer.

**Kübler-Ross.** The five-stage model of loss (denial, anger, bargaining, depression, acceptance) created by Kübler-Ross (1973) has become a highly-popularized framework for explaining normative expressions of loss and grief in American culture (Konigsberg, 2011). Moreover, the Kübler-Ross model is considered by many to be the foundational framework for conceptualizing death and grief (Pomeroy & Garcia, 2009), and continues to inform the practices of many modern-day clinicians (Pomeroy and Garcia, 2009).

Initially developed to describe how terminally ill individuals confront their own mortality, the Kübler-Ross model was later adapted to describe the stages of human bereavement, by adding the element of isolation to the denial stage, and keeping the remaining four stages unchanged (Humphrey & Zimpfer, 2008; Konigsberg, 2011, Pomeroy & Garcia, 2009). A key limitation of the Kübler-Ross model is that it characterizes normative experiences of grief, but it fails to address the complexities and complications that can be associated with the bereavement process (Doughty et al., 2011; Konigsberg, 2011; Love, 2007). Although initially criticized for its rigid and fixed stage progression (Pomeroy & Garcia, 2009), the modern perspective of the Kübler-Ross model suggests that the five stages are not linear, but rather they are potential behaviors and emotions featured in an individual's overall process of bereavement (Humphrey & Zimpfer, 2008).

**Rando.** Informed by the Kübler-Ross model, Rando's three-phase grief model also addresses bereavement in a normative context without attending to issues and concerns associated with pathological grief responses (Love, 2007). In the first phase, *avoidance*, individuals begin to accept the reality of the loss. The avoidance period is characterized by



disorganization and denial. The second phase, *confrontation*, is a period of acute grief. During this phase individuals work with acknowledging and expressing the emotions associated with the loss. In the third phase, *accommodation*, the grief associated with the loss begins to diminish and individuals experience an increased ability to re-engage in life. During this final phase, individuals redirect their attention into new and existing relationships and adjust to environmental changes associated with the loss (Jeffreys, 2005; Pomeroy & Garcia, 2009). In addition to these three phases, Rando also outlined six processes that are associated with the process of grief resolution: recognizing what has been lost, reacting to the experience of separation, recollecting and re-experiencing the relationship with the lost loved one, relinquishing former attachments, readjusting to a new personal reality, and reinvesting energy into new activities and relationships (Jeffreys, 2005).

**Freud.** A great deal of the literature refers to the fact that Freud was among the first people to conceptualize the nature and function of grief and to address the dysfunction that can exist in the bereavement process (Gross, 2016). Freud used the term *melancholia* to indicate a complicated (or pathological) response to grief, describing symptoms that closely mimic those associated with a modern clinical depressive disorder (American Psychiatric Association, 2013; Gross, 2016). Conversely, Freud used the term *mourning* to indicate an uncomplicated, or normative, response to the loss of a beloved object or person (Gross, 2016). Whether normative or complicated in nature, Freud expected the experience of grief to be a painful one, given the substantial amount of psychological attention previously extended by the bereaved towards that which was lost (Gross, 2016).

At its core, Freud's perspective of mourning was one of detachment, wherein the bereaved must come to terms with the conflicting inner desire to retain a hold on the lost object

or person, while growing increasingly aware that contact is no longer possible (Gross, 2016). In order to move through and resolve the process of detachment, Freud believed the bereaved should focus persistently on the memories associated with the object or person to whom they were previously attached, then completely withdraw all emotional attachment to the lost loved one, and ultimately redirect the psychological energy of the lost bond into an attachment with a new individual (Gross, 2016; Pomeroy & Garcia, 2009). Freud also suggested that grief had a cognitive component, which involved directly confronting one's bereavement experience, so as to accept the reality of the loss and prevent negative health outcomes (Gross, 2016).

Freud's focus on the emotional and cognitive aspects of grief, while addressing key internal processes, failed to acknowledge the significant social aspects of grief (Pomeroy & Garcia, 2009). However, a core tenet of his grief work philosophy, notably the importance of the relational attachment in the bereavement process, was a key factor in the development of Bowlby's theory of loss and attachment (Worden, 2002).

**Lindemann.** Building on Freud's detachment model, Lindemann envisioned a task-based model of "grief work" featuring three distinct tasks: (a) releasing the prior psychological and emotional attachment to the loved one, b) making environmental adjustments to life without the presence of the loved one, and c) developing new relationships (Humphrey & Zimpfer, 2008; Pomeroy & Garcia, 2009). In addition, Lindemann characterized the first four to six weeks of the grief process as the acute or crisis phase, and he noted six factors typically present for the bereaved during this initial time frame: perseverative thoughts about the lost loved one, feelings of guilt, a decrease in life functioning, somatic complaints, hostility towards others, and a tendency to internalize and display attributes formerly possessed by the deceased (Gross, 2016;

Pomeroy & Garcia, 2009). Lindemann's work later informed theories regarding both crisis intervention and traumatic bereavement (Pomeroy & Garcia, 2009).

**Parkes and Weiss.** Parkes and Weiss also proposed a task-based model of grief that featured three distinct tasks: (a) loss recognition and explanation, in which the bereaved can cognitively understand the loss and make sense of it, b) emotional resolution, in which the bereaved confronts their memories and any associated feelings of loss until they can do so without pain, and c) identity transition, in which the bereaved accepts the change in personal identity associated with the loss (Jeffreys, 2005). This model encourages confrontation, acceptance, and the development of a new sense of identity without the significant other (Jeffreys, 2005).

**Bowlby.** Bowlby's conceptualization of the grief process grew out of his theory of attachment (Pomeroy & Garcia, 2009). Bowlby believed that the process of grief and loss mirrored the attachment experience (Pomeroy & Garcia, 2009), in that bereavement compels an individual to fill the space previously occupied by the deceased and to develop new relational attachments (Humphrey & Zimpfer, 2008). To that end, Bowlby developed a four-phase model to explain the psychological aspects and processes of grief (Humphrey & Zimpfer, 2008; Jeffreys, 2005).

In the first phase, *numbing*, which may last days or several weeks, the grieving individual undergoes a primarily internal process of denial and emotional shutdown, which may look fairly normal to outsiders (Jeffreys, 2005). In the second phase, *yearning and searching*, the individual may appear outwardly agitated in response to the internal distress caused by the ruptured attachment bond, and this person is increasingly likely to exhibit behaviors intended to recover a feeling of attachment to the deceased (Jeffreys, 2005). In the third phase, *disorganization and*

*despair*, the individual begins to acknowledge that the loss is permanent, and feelings of melancholy, lethargy, and indifference surface, interfering with the individual's ability to fully engage in life tasks (Jeffreys, 2005). In the fourth and final phase, *reorganization*, the individual begins to redefine the self outside the context of the loss and to generate new frameworks of thoughts, feelings, and behaviors that eventually allow adjustment to and engagement in a life without the former attachment figure to occur (Jeffreys, 2005).

Although this model was intended for use in the case of normative bereavement (Kosminsky & Jordan, 2016), Bowlby also recognized that grief occurs along a continuum from a notable lack of mourning at one end, to a state of chronic mourning at the other (Kosminsky & Jordan, 2016). Bowlby described the state of chronic mourning as one in which the bereaved is unable to engage in typical daily tasks due to a state of persistent hyper-attention on the yearning, pain, and fear associated with the loss (Kosminsky & Jordan, 2016).

**Worden.** Worden (2002) developed a four-task grief facilitation model inspired in part by Freud's "grief work" model, and in part by Bowlby's attachment-based model of loss (Humphrey & Zimpher, 2008). Worden (2002) believed that an individual could not fully resolve their bereavement experience without completing four essential grief tasks: accepting the reality of the loss, working through the pain of the grief, adjusting to an environment without the deceased, and developing a way to experience a continuing bond with the deceased that allowed them to move on with their lives (pp. 27-36). In addition, Worden (2002) believed that the severity of an individual's grief response was informed by seven key factors, which he referred to as the "mediators of mourning" (p. 38). These factors included the role of the lost loved in the individual's life, the nature of the attachment, the circumstances of the death, the history of prior losses, personal variables (age, gender, coping style, attachment style, cognitive style, ego

strength, and world view), social variables (availability of support, perception of support, extent of social network, and spiritual resources), and concurrent life stressors.

**Ströebe and Schut.** Unlike models based on tasks, stages, or phases, the dual process model developed by Ströebe & Schut (2001a) suggests that a bereaved individual repeatedly vacillates between two distinct areas of grief processing: loss orientation and restoration orientation (Jeffreys, 2005; Ströebe & Schut, 2001a; W. Ströebe & Schut, 2001b). When engaged in loss-orientation, the individual will exhibit behaviors associated with expressing and releasing the emotions brought forth by the loss (Jeffreys, 2005). During restoration orientation, the individual exhibits behaviors intended to create a new sense of identity and meaning in life without the deceased (Jeffreys, 2005).

**Klass.** The concept of continuing bonds, as proposed by Klass, was initially developed to address the healing process involved with parents experiencing the death of a child; however, the construct was later broadly applied to grieving individuals in other types of relationship dynamics (Jeffreys, 2005). In this model, bereaved individuals need to change their previously held images of lost significant others to ones that fit within their new reality without the deceased (Jeffreys, 2005). Then, they need to bond to those newly conceived images as a means of maintaining an ongoing sense of connection with lost significant others (Jeffreys, 2005). Once these internal models of lost loved ones are updated, bereaved individuals must determine how their own identities will update and share that new sense of self with those in their social networks (Jeffreys, 2005).

**Neimeyer.** Neimeyer's meaning reconstruction model of grief is based on the premise that individuals create an ongoing personal narrative of their lives, in which their thoughts, feelings, and actions create smaller narratives of everyday experience, which in turn are

consolidated into larger overarching narratives that individuals can use to understand themselves both as an individual, and as part of a broader social community (Jeffreys, 2005, Neimeyer, 2001). In the context of bereavement, Neimeyer suggested that clinicians use this understanding of bereaved individuals' pre-loss narratives to help them reconstruct post-loss narratives that could provide a sense of meaning for their post-loss lives (Jeffreys, 2005, Neimeyer, 2001).

This section addressed the identified need for mental health professionals to be familiar with a range of grief models as a theoretical foundation for understanding how individuals process grief. As such, a number of key findings are presented in this section. To begin with, although some models, such as those offered by Kübler-Ross and Rando, are based on a normative presentation of grief, the majority of the models presented herein are based on the notion that bereaved individuals experience some type of dysfunction as part of their grief experiences. For example, Freud believed that some individuals experience grief complications that mimic present day conceptualizations of depressive disorders. Freud also believed that attachment bonds were an important component of the bereavement experience, in that individuals need to redirect the psychological energy previously invested in lost relational bonds into new relational attachments.

In addition, Freud suggested that individuals needed to apply themselves to the process of resolving these dysfunctional grief responses. To that end, a number of the grief models presented, including those by Lindemann, Parkes and Weiss, and Worden, focused on the concept of grief resolution as a series of tasks bereaved individuals need to complete. Like Freud, Bowlby believed that attachment bonds influence the bereavement process, but rather than conceptualizing grief as a series of tasks to be completed, Bowlby framed bereavement in terms of a series of experiential phases that individuals progress through in order to resolve their

grief issues. In addition to stage, task, and phase models, other grief theorists presented models that conceptualized grief resolution in terms of processes (Ströbe & Schut), continuing bonds (Klass), and personal narratives (Neimeyer). Overall, this presentation of grief theories summarized the key findings identified in the literature as pertinent to a clinical understanding of grief and loss.

To best utilize this information about grief models in clinical practice, counselors need to consider which model or models offer the best fit with their own views on grief and loss. For example, a clinician who is guided by psychodynamic principles may feel more naturally aligned with Freud's perspective on grief. At the same time, counselors need to be cognizant of the ways in which their clients experience and process losses, and do their best to integrate any differences in grief perspectives in ways that best serve the needs of their clients. Ultimately, this overview of grief theories and models should provide clinicians with a solid foundation from which to clarify their own theoretical orientations informing work with loss and grief, conceptualization of how clients' process and resolve losses, and formulation of treatment plans that facilitate healing in their clients. Along with a theoretical understanding of grief, mental health professionals should be able to identify essential grief factors and be familiar with their influence on the bereavement process.

### **Grief Variables**

The mediators of mourning framework developed by Worden identified seven key variables that inform the intensity of an individual's grief response (Jeffreys, 2005; Worden, 2002). These variables include (a) the role of the significant other in the life of the bereaved, (b) the nature of the relationship, (c) the circumstances of the loss, (d) the individual's history of loss, (e) the individual's personality factors (attachment style, ego strength, age, gender, and

spiritual beliefs), (f) social responses to the individual's loss, and (g) the presence of concurrent stressors in the individual's life (Jeffreys, 2005). An individual's grief response may also be influenced by their stage of development (Hooyman & Kramer, 2006), cultural background (American Psychiatric Association, 2013, Houben, 2012; Parkes, 2013), and perceived availability of social support (Butler & Degraff, 1996).

The identification of factors that influence grief responses was another key finding of the literature review. To that end, clinicians can utilize Worden's mediators of mourning framework to guide the collection of this essential clinical data during the grief assessment process. Combined with the data collected about an individual's grief presentation, mental health professionals need to have an initial snapshot of the individual's bereavement experience. Moreover, the data collected regarding grief components and factors can be used to help determine whether or not the client is having a complicated grief reaction.

### **Understanding Complicated Grief**

Bowlby believed that individuals experience grief complications to varying degrees, (Jeffreys, 2005). This premise was supported in the literature review, which revealed only 10% to 20% of bereaved individuals exhibit complicated grief reactions (Hensley, 2006; Neimeyer & Currier, 2009; Shear & Mulhare, 2008). Moreover, the literature review identified three primary distinctions that are used to guide the assessment of complicated grief reactions: (a) the degree of symptom severity, (b) the duration of bereavement concerns, and (c) the profundity and extent of life dysfunction (Jeffreys, 2005).

In terms of severity, individuals who experience complicated grief are likely to struggle with intense, persistent distressing thoughts, including suicidal or homicidal ideation, intense feelings of dissatisfaction, hopelessness, emptiness, and regret, as well as affective symptoms



typically associated with anxiety or depression (Jeffreys, 2005; Love, 2007; Neimeyer & Currier, 2009; Zhang et al., 2006). In addition, individuals experiencing complicated grief tend to feel socially isolated and may employ persistent avoidance in a dysfunctional attempt to manage the pain and other intense emotions associated with their losses (Shear et al., 2007). In particular, these individuals tend to avoid locations associated with the death, situations that are likely to elicit sympathy (e.g. attending a funeral), and activities that remind them of their losses (Shear et al., 2007). A severe lack of self-care and a distinct lack of mobilization to life tasks are additional symptoms associated with complicated grief, as individuals may focus on their losses to the exclusion of anything else (Jeffreys, 2005; Shear et al., 2007).

Second, in terms of duration, most bereaved individuals are able to reach a sense of resolution regarding their loss within a period of six months, as evidenced by their ability to participate in vocational tasks, experience joy and pleasure, and imagine forming new social relationships (Zhang et al., 2006). However, those who experience complicated grief reactions struggle to integrate their losses and resist adapting to lives that do not include their deceased loved ones (Shear & Mulhare, 2008). Although a majority of individuals begin to grieve their losses within this time frame, clinicians should be aware that others experience inhibited or delayed grief responses (Jeffreys, 2005). These delayed patterns of bereavement typically occur when individuals (a) use avoidance as their primary coping strategy, (b) are preoccupied with other life commitments, or (c) do not feel safe expressing the thoughts and feelings associated with their losses (Jeffreys, 2005).

Third, in evaluating the extent of dysfunction that individuals are experiencing, counselors are strongly encouraged to consider how their clients' losses are impacting various life domains, such as those related to family, home, vocation, and community (Jeffreys, 2005).

When clients are unable, on an ongoing basis, to return to an approximate level of pre-loss functioning in any of these essential life areas, complicated grief is implicated (Jeffreys, 2005). In extreme cases, the severity of dysfunction may require hospitalization (Jeffreys, 2005).

The literature review also indicated that individuals who shared significant attachment bonds with their deceased loved ones may be more vulnerable to complicated grief reactions, particularly if they are unable or unwilling to accept their losses or to revise and update their former attachments (Jeffreys, 2005). These individuals may intentionally perpetuate their grief experiences in a dysfunctional attempt to maintain their connections with the deceased (Jeffreys, 2005). In addition, individuals with insecure-anxious attachment styles may be more dependent on their bonds with significant attachment figures, resulting in their being more preoccupied and distressed by their losses (Jeffreys, 2005). Other risk factors that predispose individuals to complicated grief reactions include a prior history of mood disorders, being female, having inadequate social support, lacking a spiritual belief system, and possessing insufficient inner resources or coping skills (Chiu et al., 2010; Jeffreys, 2005).

This section discussed key findings about what clinicians need to know about complicated grief. To begin with, the literature review identified the three key determinants of complicated grief. The literature review also revealed a number of risk factors that predispose individuals to complicated grief responses. As the components of grief often mimic the symptoms of mental health disorders, mental health professionals must also be prepared to assess bereaved clients for potential co-occurring mental health disorders.

### **Clinical Grief Assessment in the DSM**

Ethical clinical practice requires that mental health practitioners be competent in dealing with client issues relevant to death and dying (Layman & Swenson, 2013). Moreover, one of the

most critical elements in grief assessment is determining whether or not a client's bereavement symptoms are representative of a normal grief response or are indicative of a co-occurring mental disorder (American Psychiatric Association, 2013). To that end, clinicians should be familiar with how grief is addressed in the DSM-V (American Psychiatric Association, 2013) and how to utilize differential diagnosis to evaluate the possibility of comorbid mental health issues, such as depressive disorders, stress disorders, or substance abuse (American Psychiatric Association, 2013; Bandini, 2015).

**History of clinical grief diagnosis.** The issue of bereavement was initially addressed in the *Diagnostic and Statistical Manual of Mental Health Disorders, Third Edition* (DSM III; American Psychiatric Association, 1980) as a V-code associated with factors known to impact an individual's health status and potentially require professional support (Bandini, 2015). V-codes described environmental, contextual, and psychosocial components of conditions (American Psychiatric Association, 2013). The DSM-III described uncomplicated grief as an expected response to loss, featuring depressive symptoms such as insomnia, impaired appetite, and weight loss (American Psychiatric Association, 1980). The DSM-III further suggested that a grief reaction might be complicated by major depression if the client presented with severe bereavement symptoms, such as a "morbid preoccupation with worthlessness, prolonged and marked functional impairment, and marked psychomotor retardation" (American Psychiatric Association, 1980, p. 333).

With the advent of the *Diagnostic and Statistical Manual of Mental Health Disorders, Fourth Edition* (DSM-IV; American Psychiatric Association, 1994), depressive symptoms associated with bereavement were not thought to be clinically significant unless they persisted for more than two months past the time of the initial loss. In order to distinguish a normal grief

reaction from a clinically-relevant depressive state, the DSM-IV offered the following potential indicators of a depressive event: feelings of guilt (other than those associated with behaviors which occurred, or did not occur, at the time of death), ongoing thoughts about dying (other than those linked to the benefits or preference of having died with the deceased loved one), delusional experiences (other than briefly imagining seeing or hearing the deceased), notable psychomotor impairment, notable and extended impairment of functioning, or an unrelenting sense of worthlessness (American Psychiatric Association, 1994).

In terms of diagnostic timing, in order to assign a depression-related diagnosis under the DSM-IV, pertinent bereavement symptoms needed to have persisted for a minimum of two weeks; a two-month, post-loss waiting period was also required (Bandini, 2015). However, under the *Diagnostic and Statistical Manual of Mental Health Disorders, Fifth Edition* (DSM-V; American Psychiatric Association, 2013), the two-month, post-loss waiting period was eliminated, allowing a diagnosis of major depression to be assigned to an individual after only two weeks of persistent bereavement-related depressive symptoms (Bandini, 2015).

**Current standards for clinical grief diagnosis.** Although proposed disorders included in the DSM-V as “conditions for further study” are not intended for current clinical use, the newly proposed diagnostic criteria for persistent complex bereavement disorder (see Appendix B) may assist mental health professionals in distinguishing between normative and pathological bereavement symptoms, as part of a larger assessment of grief (American Psychiatric Association, 2013, p. 783). Specifically, clinicians can use this set of criteria to identify parameters associated with the nature of the relationship, the period of bereavement, reactive distress, social/identity disruption, functional impairment, and normative evaluation.

***Persistent complex bereavement disorder.*** This proposed disorder features five diagnostic criteria along with one possible specifier. Proposed diagnostic Criteria A indicates that the individual must have “experienced the death of someone with whom he or she had a close relationship” (American Psychiatric Association, 2013, p. 789). In terms of timing, proposed Criteria B requires that the individual must have experienced at least one out of four bereavement symptoms related to emotional pain or loss preoccupation, during a grieving period of at least 12 months for adults, or at least six months for children (American Psychiatric Association, 2013). As previously noted, this is a significant increase in the time frame required for a grief response to be considered pathological (American Psychiatric Association, 1980; American Psychiatric Association, 1994; American Psychiatric Association, 2013; Bandini, 2015). Utilizing the same time frame specified in proposed Criteria B (12 months for adults/six months for children), proposed Criteria C requires the individual to have experienced at least six out of 12 possible symptoms, half of which describe a “reactive distress to the death,” and half of which describe “social/identity disruption” (American Psychiatric Association, 2013, p. 790). Proposed Criteria D requires “clinically significant distress or impairment in social, occupational, or other important areas of functioning,” (American Psychiatric Association, 2013); whereas, proposed Criteria E requires the nature of the individual’s bereavement response to be “out of proportion to or inconsistent with cultural, religious, or age-appropriate norms” (American Psychiatric Association, 2013, p. 790). Finally, the proposed specifier, “with traumatic bereavement” is indicated when the loss is “due to homicide or suicide with distressing preoccupations regarding the traumatic nature of the death...including the deceased’s last moments, degree of suffering and mutilating injury, or the malicious or intentional nature of the death” (American Psychiatric Association, 2013, p. 790).

The prevalence rate associated with persistent complex bereavement disorder is an approximate range of 2.4%-4.8% with women being more likely to experience the disorder than men (American Psychiatric Association, 2013, p. 791). In addition to gender considerations, individuals are at greater risk for this disorder if the deceased was a child or if the bereaved experienced a notable dependency on the lost loved one (American Psychiatric Association, 2013). Individuals with this disorder are also at increased risk for suicidal ideation (American Psychiatric Association, 2013). Although the symptoms associated with this disorder typically show up in relative proximity to the death, it is possible for symptoms to be delayed for months or years (American Psychiatric Association, 2013).

***Differential diagnosis.*** The experience of bereavement is associated with an increased risk for developing a mental health disorder and for using substances as a coping strategy (Fox & Jones, 2012). Further, substance use disorders, PTSD, and major depressive disorder are the most common comorbid disorders experienced with persistent complex bereavement disorder, and differential diagnosis may be required to distinguish one from the others (American Psychiatric Association, 2013).

Bereavement and depressive disorders, particularly major depressive disorder and persistent depressive disorder, share many common elements including negative somatic impacts, impaired cognitive functioning, suicidal ideation, and feelings of emptiness, irritability, or sadness (American Psychiatric Association, 2013). However, although grief may promote an experience of intense suffering in bereaved individuals, it is unusual for normal bereavement responses to instigate clinically-significant depressive episodes, particularly if the individuals have not historically exhibited depressive symptoms (American Psychiatric Association, 2013). Moreover, there are notable differences between normative bereavement responses and major

depressive episodes. For example, normal grief is primarily characterized by feelings of loss and emptiness, which often occur as waves of feeling and typically decrease over time, while symptoms of a major depressive episode include a persistent, depressed affect, with unrelenting feelings of misery, hopelessness, and worthlessness, as well as pessimistic and self-critical thoughts (American Psychiatric Association, 2013).

When bereaved clients meet some but not all of the criteria for a depressive disorder, the clinician might want to consider a diagnosis of adjustment disorder with depressed mood: “Adjustment disorders may be diagnosed following the death of a loved one when the intensity, quality, or persistence of grief reactions exceed what normally might be expected, [and] when cultural, religious, or age-appropriate norms are taken into account” (American Psychiatric Association, 2013, p. 287). Further complicating the diagnostic process, recent bereavement research indicates that depression caused by grief is not substantially different from depression associated with other life stressors, and that when a bereaved individual’s access to treatment for persistent, depressive symptoms is delayed, the individual may subsequently experience more substantial depressive symptoms (Bandini, 2015).

When the death of the loved one was a traumatic experience, the individual may develop symptoms of both posttraumatic stress disorder (PTSD) and persistent complex bereavement disorder (American Psychiatric Association, 2013). Although avoidance behaviors and intrusive thoughts are associated with both disorders, the presentations of these symptoms are distinct to each (American Psychiatric Association, 2013). For example, individuals with persistent complex bereavement disorder are likely to both perseverate about the loss and long for reconnection with the deceased, unlike the unilateral experience of avoidance in PTSD, which typically involves a “consistent avoidance of internal and external reminders of the traumatic

experience” (American Psychiatric Association, 2013, p. 792). Similarly, in the case of PTSD, intrusive thoughts tend to focus on the traumatic event itself; whereas, in the case of persistent complex bereavement disorder, intrusive thoughts may focus on any number of positive elements associated with the relationship to the deceased, as well as feelings of upset associated with the experience of separation from the loved one (American Psychiatric Association, 2013). When the death does not involve violent or traumatic circumstances, but the individual displays similar stress responses, a diagnosis of acute stress disorder should be considered (American Psychiatric Association, 2013).

In the case of anxiety symptoms, it is considered normal and appropriate for the bereaved client to experience “intense yearning or longing for the deceased, intense sorrow and emotional pain, and preoccupation with the deceased or the circumstances of the death” (American Psychiatric Association, 2013, p. 194). However, anxiety and fear associated with being disconnected from attachment figures other than the deceased is indicative of separation anxiety disorder. Similarly, the symptoms of generalized anxiety disorder may overlap with those associated with normal, grief-driven anxiety and stress (Casey & Strain, 2016).

In review, an examination of the literature yielded several key findings about clinical grief assessment. To begin with, since its initial inclusion in the DSM-III, the diagnostic consideration of grief in the DSM has continued to evolve over time. As an example, a newly proposed conceptualization of complicated grief, persistent complex bereavement disorder, is currently featured in the DSM-V as a condition for further study. The DSM-V acknowledges that some grief presentations are characterized by uncomplicated, normative responses while others include complicated, pathological responses. Moreover, complicated grief responses often share key characteristics with a number of identified mental health disorders. As such,



clinicians must understand that differential diagnosis may be necessary to appropriately interpret complicated grief symptoms. To further aid the assessment of complicated grief, mental health practitioners may also want to employ the use of targeted assessment instruments.

### **Assessment Instruments**

Grief impacts individuals in a variety of ways, and although no single assessment instrument comprehensively addresses every factor of grief (Altmaier, 2011), certain instruments may facilitate the grief assessment process by helping clinicians determine whether or not a client is at risk for (or currently experiencing) a complicated grief response (Boelen & Prigerson, 2007; Bui et al., 2015; Jordan, Baker, Matteis, Rosenthal, & Ware, 2015). For example, the Texas Revised Inventory of Grief (TRIG) provides data on the progression of the individual's bereavement process, the Core Bereavement Items (CBI) provides data on the intensity of grief responses to a recent loss, and the Hogan Grief Reaction Checklist (HGRC) provides data that serve to distinguish normal grief from anxiety or depression (Altmaier, 2011). In addition, the Grief Evaluation Measure (GEM) is a comprehensive tool that both identifies the presence of complicated grief factors (Layman & Swenson, 2013) and predicts an individual's adjustment status following a year of bereavement (Jordan et al., 2005).

As attachment roles have been shown to have a profound impact on the grieving process (Kominsky & Jordan, 2016), clinicians may also want to use tools that provide information about the attachment bond between the bereaved and the deceased (Ravitz et al., 2010). For example, the Relationship Questionnaire (RQ) is particularly useful in examining the relationship between adult attachment styles and affective issues, such as anxiety and depression (Ravitz et al., 2010). In addition, the Adult Attachment Scale (AAS) and the Revised Adult Attachment Scale (RAAS) provide data on an individual's "comfort with emotional closeness, comfort with depending or

trusting in others, and anxious concern about being abandoned or unloved” (Ravitz et al., 2010, p. 425).

The identification of assessment instruments that can assist mental health professionals with evaluating complicated grief factors and understanding a bereaved individual’s attachment profile was another key finding of this literature review. Based on the relevant assessment data identified in this section, mental health professionals should be able to determine whether or not an individual is experiencing a complicated grief reaction. Once this determination is made, clinicians can make appropriate intervention recommendations.

### **Grief Interventions**

Although many have theorized about how humans process loss, some suggest that grief work is unnecessary for individuals having a normative bereavement reaction (Cicchetti, 2010; Jordan & Neimeyer, 2003; Larson & Hoyt, 2007). For example, in a comprehensive literature review covering 30 years of grief therapy studies, Neimeyer and Currier (2009) found that grief interventions, when offered to individuals experiencing uncomplicated bereavements, were only somewhat to moderately effective in mitigating grief symptoms. Moreover, without explicit grief interventions, uncomplicated grievers were often capable of generating positive bereavement outcomes by simply drawing on their innate resilience capacities (Neimeyer & Currier, 2009).

**Uncomplicated grief.** Despite their potential ability to independently navigate the normal difficulties associated with bereavement, uncomplicated grievers may seek professional assistance, particularly during the initial two months of mourning, when the experience of grief tends to be the most acute (Jeffreys, 2005). Under these circumstances, mental health professionals should engage clients by utilizing basic counseling skills, such as attending,

empathizing, allowing silence, and reframing (Haney & Liebsohn, 1998; McNicholas & Collis, 1995). In addition, counselors can provide needed support by being respectful, avoiding judgment, being sensitive to a client's cultural or spiritual traditions, being careful not to trivialize the client's experience, avoiding clichéd responses, normalizing the experience for the client, and providing explicit permission for the client to grieve (Knight & Gitterman, 2013; McNicholas & Collis, 1995).

***Grief techniques.*** A number of specific techniques have been identified as being useful in providing normative grief support (Worden, 2002). For example, using evocative language can help clients to connect with the reality of the loss and may facilitate the client's access to key emotional material (Worden, 2002). Using symbols, such as having a client bring in pictures, items of clothing, or other tangible markers of the deceased, can assist the counselor in better understanding the role of the lost loved and the nature of the relationship (Worden, 2002). Incorporating symbols in this way can also help facilitate the creation of a memory book, which can be a beneficial grief integration tool (Worden, 2002). Addressing the loss metaphorically can be particularly beneficial for the client who needs to confront the loss in a less direct and painful way (Worden, 2002).

Having the client journal about their experience, or write letters to the deceased, can help clients personalize the loss and process associated feelings (Worden, 2002). Similarly, artistic expression of the client's loss experience through drawing or painting can help the client to process feelings, notice unidentified inner conflicts, and become increasingly aware of the various components of what has been lost (Worden, 2002). This expressive process can also provide clinicians with information as to the degree of progress the client has made towards resolving the loss (Worden, 2002). Role playing and directed imagery are two additional

techniques that can help the client both build new skills and verbally express what they need to say, either to dismissive friends and family, or to the deceased (Worden, 2002). Overall, these grief techniques can be utilized to support the client in processing and expressing the thoughts and feelings associated with their loss (Worden, 2002).

***Counselor self-awareness.*** In order to provide effective therapeutic services, mental health professionals must be also prepared for the intense nature of grief work (Knight & Gitterman, 2013; Worden, 2002). To that end, counselors are more likely to feel comfortable discussing issues of loss and grief with clients if they have taken the time to explore their personal thoughts and feelings about death (Knight & Gitterman, 2013; Worden, 2002). By exploring their own loss history, counselors will be in a better place to empathize with their client's loss experience, to understand what techniques and interventions might prove most supportive, and to target community and self-help resources (Worden, 2002). This need for self-exploration is particularly relevant when a client's loss bears similarities to a loss the clinician has experienced in the past, or to a loss they are worried may happen in the future (Worden, 2002). With this in mind, clinicians should also be prepared to acknowledge any counter-transference that might arise (Knight & Gitterman, 2013), and to consider and address the possibilities of vicarious trauma and compassion fatigue (Knight & Gitterman, 2013; Pearlman, Wortman, Feuer, Farber, & Rando, 2014). Finally, counselors should identify avenues for accessing help and support for themselves (Worden, 2002). If they feel overwhelmed by unresolved personal losses, specifically those that are triggered by the client's experiences, counselors should be prepared to provide a referral to another clinician (Worden, 2002).

**Complicated grief.** When the assessment data points to a complicated grief reaction, the literature suggests utilizing the following intervention models: interpersonal therapy (IPT) and

cognitive behavior therapy (CBT). These specific intervention models can be used in conjunction with the basic counseling skills and techniques previously described in the context of uncomplicated grief responses.

***Interpersonal therapy (IPT).*** IPT focuses on Bowlby's attachment theory as a means of understanding a client's relational issues, the impact of maladaptive attachment responses, and how these responses create social challenges which may impair an individual's ability to manage interpersonal crises or to generate effective social support networks (Stuart & Robertson, 2012). Moreover, IPT is based on the assumption that attachment needs are not typically met when social support is inadequate during times of significant distress (Stuart & Robertson, 2012). Thus, IPT is utilized to assist individuals with both communicating their needs effectively and developing social networks that feature dependable support. Moreover, therapeutic tasks associated with the implementation of IPT include the development of solid therapeutic alliances with clients, the identification of clients' dysfunctional communication strategies, the modification and practice of updated communication strategies, and the construction of an improved network of social support (Stuart & Robertson, 2012). IPT is typically short-term and strengths-based in nature (Shear & Mulhare, 2008) and has been successfully employed in addressing both complicated bereavement (Wetherell, 2012) and grief-related major depression (Moayedoddin & Markowitz, 2015).

***Cognitive-behavioral therapy (CBT).*** Although not a derivative of attachment theory, CBT has been widely utilized in supporting issues related to bereavement, particularly complicated bereavement (Boelen, 2006; Boelen, de Keijser, van den Hout, & van den Bout, 2007; Hensley, 2006; Matthews & Marwit, 2004; Neimeyer, Harris, Winokuer, & Thornton, 2011; Wagner, Knaevelsrud, & Maercker, 2006; Wagner & Maercker, 2007; Wetherell, 2012).

CBT contends that cognitions are the primary factors in determining what a person feels and how they choose to act (Corey, 2009). CBT is used to help clients examine their faulty assumptions and misconceptions in order to replace problematic belief patterns with more effective ways of thinking, thereby promoting improved behavioral outcomes (Corey, 2009). CBT has been successfully utilized in treating the affective challenges associated with bereavement and in addressing maladaptive thoughts and behaviors which might otherwise complicate the bereavement process (Boelen, 2006).

In particular, CBT can be beneficial in addressing three notable clinical concerns associated with the onset and persistence of complicated grief: “(a) insufficient integration of the loss into the autobiographical knowledge base, (b) negative global beliefs and misinterpretations of grief reactions, and (c) anxious and depressive avoidance strategies” (Boelen, van den Hout, & van den Bout, 2006, p. 109). Further, CBT can be used to address these three targeted aspects of complicated grief by (a) using exposure methods to help clients process and integrate their losses, (b) presenting cognitive challenges to help clients identify and modify dysfunctional interpretations and beliefs, and (c) replacing dysfunctional avoidance strategies with supportive approaches that encourage healthy bereavement adjustments (Boelen et al, 2006).

Lacking a significant integration of their losses, individuals with complicated grief reactions often found their loss experiences to be easily triggered by emotional, cognitive, and environmental cues and were likely to categorize the loss events as significant, distinct, and emotional (Boelen et al., 2006). In addition, the pervasive tendency in these individuals to cling to negative interpretations and beliefs of grief events may increase their use of maladaptive avoidance strategies and negatively impact their ability to adjust to their losses (Boelen et al., 2006). Moreover, individuals experiencing complicated grief tend to use two primary types of

avoidance strategies: (a) anxious avoidance strategies are employed to manage the aspects of losses which are more internal in nature, such as feelings, thoughts, and memories, and (b) depressive avoidance strategies are used to manage the more external features of losses, such as social isolation and inactivity (Boelen et al., 2006).

Some research suggests that symptoms of complicated grief are not mitigated by treatments designed primarily to target depression (Shear & Mulhare, 2008). However, recent findings suggest that individuals experiencing complicated grief (as evidenced by a score of 30 points or higher on the Inventory of Complicated Grief) with co-occurring depressive symptoms might benefit from a combination of complicated grief therapy and the psychopharmaceutical drug citalopram (Watts, 2016). Complicated grief therapy is a treatment modality that uses specific techniques from both IPT and CBT. Interestingly, the drug was not found to provide significant benefits when given without the specific accompanying psychotherapy intervention (Watts, 2016). Since most mental health practitioners do not prescribe medications, a referral to a physician might be appropriate when this constellation of bereavement and depressive symptoms is observed (Jordan & Litz, 2014; Neimeyer, 2012).

This section yielded several key findings about grief interventions. For example, clients experiencing uncomplicated losses may not need professional interventions, as many uncomplicated grievers may be able to process their losses by relying on their own inner resources and available social supports. However, when bereaved individuals do pursue professional grief support, counselors should utilize basic counseling skills and identified techniques to build rapport and facilitate clients' grief narratives. In order to be prepared for the challenges associated with grief counseling, the literature further identified the need for counselors to examine their beliefs about death and their own experiences with loss and grief.

Additional key findings in this section included the identification of IPT and CBT as proven treatments for complicated grief reactions.

Regarding the field of grief counseling, key findings indicate that mental health professionals need to be familiar with a number of specific related topics, including the relationship between attachment bonds and grief and the components of grief. In addition, having an understanding of the theories and models used to conceptualize the experience of loss provides an important clinical foundation. In addition, clinicians need to be acquainted with the key factors associated with the bereavement process and the differences between uncomplicated and complicated grief reactions. Further, counselors need to be conversant with the way grief is conceptualized in the DSM-V and how differential diagnosis can be utilized to distinguish significant loss reactions from mental health issues with similar symptoms. An introduction to relevant assessment instruments can prove helpful in measuring grief and attachment variables. Mental health professionals also need to be cognizant of general interventions for uncomplicated grief and more specific interventions for complicated grief. Armed with this knowledge base, clinicians should be prepared to address the most commonly occurring issues associated with bereavement in adult populations. The next section of the literature review builds on this educational foundation in grief counseling and presents key findings associated with grief counseling in the specific context of pet loss and bereavement.

### **Pet Loss Counseling**

The process of bereavement is a natural response to loss, whether for pet or human losses (Brown et al., 2001). Moreover, individuals are likely to respond to the loss of their pets in a similar manner, and with the same degree of intensity, as they might respond to losing a human member of their families (Archer & Winchester, 1994; Bobier, 2011; Brown et al., 2001;



Clements et al., 2003; Quackenbush & Graveline, 1985). Under traditional circumstances of loss, mental health clinicians should be able to differentiate between normative, depressive symptoms of grief and severe, pathological indicators of bereavement (Bandini, 2015). This assessment process is equally important in the case of pet loss (Janssen, 2016).

Although Turner (1998) suggests that counselors offer the same types of grief support to clients, whether their losses relate to people or pets, the loss of a pet may require additional consideration and support from clinicians, given the unique concerns associated with pet bereavement (McNicholas & Collis, 1995). In addition, it is essential that clinicians determine when clients are experiencing (or are likely to experience) complicated grief responses to pet loss, as these types of bereavement responses typically require professional interventions to address both the explicit losses as well as any underlying issues or co-occurring stressors (McNicholas & Collis, 1995). As such, this section provides an overview of the key issues associated with pet loss, including the symptoms and factors associated with pet grief, the elements that influence complicated pet bereavement, and identified intervention strategies and techniques.

### **Human-Pet Relationships**

According to Brown (2006), more than 50% of U.S. families have pets, and 70-90% of pet owners characterize pets as family members. Since animals live much shorter lives than humans (Corr, 2004), the loss of a companion animal may be an experience that individuals have multiple times over the course of their lives (Bobier, 2011). Yet, minimal research has been conducted to explicitly explore the feelings of grief and loss associated with the loss of a companion animal (Brown, 2006; Gosse & Barnes, 1994; Sharkin & Knox, 2003) even though

approximately 40 million individuals in the U.S. experience a new pet loss each year (Freedman, James, & James, 2014).

Pets fill a number of essential, social roles in people's lives including family member (Brown, 2006; Donohue, 2005; Fernandez-Mehler, Gloor, Sager, Lewis, & Glaus, 2013; Gage & Holcomb, 1991; Planchon et al., 2002); best friend (Butler & DeGraff, 1996; Cordaro, 2012; Durkin, 2009; Wright, 2008), surrogate child (Clements et al., 2003; Durkin, 2009; Hara, 2007; Quackenbush & Graveline, 1995; Turner, 2001); and social partner/significant other (Cordaro, 2012; Fernandez-Mehler et al., 2013). It is easy for pets to fill the role of children in the lives of some individuals, as they require ongoing care throughout their lives, and are wholly dependent on their owners for their wellbeing (Quackenbush & Graveline, 1985). Similarly, pets often fill the role of long-term companion, being part of the good times, providing critical support during the bad times, and being a silent witness to the growth and changes that have occurred over time in the owner's life (Quackenbush & Graveline, 1985). Other animals, such as police and military dogs and farm animals, fill crucial roles as work partners (Hall et al., 2004; Weisman, 1991).

Pets provide several types of social support to their owners including emotional support, esteem support, and instrumental support (McNicholas & Collis, 1995). In terms of emotional support, pets can reduce feelings of stress or loneliness; in terms of esteem support, pets affirm their owner's value, they are nonjudgmental, and their support is predictable and reliable (McNicholas & Collis, 1995). In terms of instrumental support, some pets provide needed home support, such as when a cat catches vermin or a dog provides home security, while in their role as service animals, pets provide tangible support services to their owners who experience disabilities (McNicholas & Collis, 1995).

The presence of a pet, particularly a dog, can increase social contact and expand the owner's social network (Blankman, 2002). Individuals who struggle with creating and maintaining interpersonal connections may compensate for the loss by focusing on non-human relationships to mitigate feelings of isolation and loneliness (Aydin et al., 2012). Moreover, if a pet owner has limited human contact or social relationships, their relationship with their pet may be the only way their needs for contact and companionship are met, particularly for elderly individuals (Blankman, 2002; Carmack, 1991). In addition, elderly individuals who live alone may be particularly distressed after losing a pet due to their cumulative age-related losses, such as the loss of their careers, loss of friends, loss of vitality, and loss of mobility (Quackenbush & Graveline, 1985).

Regardless of the type of role filled by the pet, human-pet relationships provide individuals with nurturance and social support (Brown, 2006), leading many individuals to form deeper attachment bonds with pets than they do with family members or other social contacts (Beder, 2013). In addition, individuals with trauma backgrounds, who have difficulty trusting others and forming adult attachments, may find that it feels safer to develop relational attachments with pets than with people (Brown & Katcher, 2001). Moreover, for some individuals, pets may be the central way their need for physical touch is accommodated, particularly among the elderly (Carmack, 1991). The relationship bonds between people and their pets may also be informed by the degree of stress relief or social support that the pet provided, as well as the degree to which the pet was integrated into the person's day-to-day routines and functions (McNicholas & Collis, 1995).

In sum, the key finding associated with this segment of the literature review is that helping professionals need to be familiar with the numerous types of essential relationships that

exist between clients and their pets (Butler & DeGraff, 1996), as well as the supportive functions that animal companions provide (McNicholas & Collis, 1995). In addition to understanding some of the significant ways in which humans connect and relate with their pets, mental health professionals should be familiar with the variety of impacts that pet loss may have on bereaved owners' lives.

### **Components of Pet Loss**

Similar to how individuals experience human-human losses, human-pet losses also affect individuals across multiple life domains, including physical, cognitive, emotional, and behavioral. The physical impacts associated with pet loss may include sleep disturbances, changes in appetite, and increased susceptibility to illness (McNicholas & Collis, 1995). Cognitive impacts may include a preoccupation with the circumstances of the loss, repetitive thoughts about the pet, a sense that some part of the self also died along with the pet, impaired concentration, an increase in obsessive-compulsive behaviors, and an impulse to search for memory markers of the pet (Archer & Winchester, 1994; Baier & Buechsel, 2012; McNicholas & Collis, 1995). Emotional impacts may include initial feelings of disbelief or numbness, extended periods of sadness or crying, heightened anxiety, depression, mood swings, and panic attacks (Archer & Winchester, 1994; Baier & Buechsel, 2012; McNicholas & Collis, 1995). Behavioral impacts may include an increase in obsessive-compulsive and isolating behaviors, along with substance abuse (Archer & Winchester, 1994). These grief responses may be initially intense, but they tend to diminish over time without professional intervention (McNicholas & Collis, 1995).

A key finding of the literature is that the grief associated with both human-human losses and human-pet losses is experienced across multiple life domains, often with symptoms similar

to other mental health concerns or disorders. In addition to specific symptoms associated with pet grief, clinicians need to consider how to best conceptualize the experiences associated with the pet bereavement process.

### **Pet Loss Models**

Although an understanding of general grief models offers clinicians an important empirical foundation, these techniques and interventions must be modified to address specific pet bereavement concerns (Turner, 2003). In reviewing the literature on pet loss, no one model was espoused as a preferred framework for pet bereavement. Not surprisingly, given its broad public recognition, the Kübler-Ross model was mentioned in both the pet loss literature and numerous self-help texts about pet loss. One of the most prominent applications of the Kübler-Ross model to pet bereavement was found in Sife's (2005) book, *"The Loss of a Pet: A Guide to Coping with the Grieving Process When a Pet Dies."* In this text, Sife presented a normative pet loss model explicitly based on the Kübler-Ross model, with only minor modifications and six explicit stages instead of five (Durkin, 2009).

In terms of applying traditional grief models to pet loss, the general concept of stage/phase models was applied to pet grief in numerous self-help texts (Carmack, 2003; Greene & Landis, 2002; Harris, 1996; Nieburg & Fischer, 1996; Quackenbush & Graveline, 1985; Sife, 2005; Wolfelt, 2004). However, the empirical data collected on the various factors associated with pet grief suggested that Worden's mediators of mourning framework might be most suitable as an adaptive model for pet loss assessment.

A key finding of this section of the literature review is that clinicians should be prepared to apply general grief theories and techniques to individuals needing clinical support for pet loss. Specifically, Worden's model was found to have a strong fit with the key identified concerns and

factors associated with the loss of a pet. The following sections of this portion of the literature review discuss the specific variables associated with pet loss, allowing a point-by-point comparison with Worden's mediators of mourning framework.

### **Essential Factors of Pet Loss**

Three variables that notably impact the experience of adult pet loss are (a) the nature and quality of the human-pet attachment bond, (b) the quality of social support available to the bereaved, and (c) the circumstances of the pet's death (Beder, 2013; Gosse & Barnes, 1994). Moreover, these three pet loss factors have been found to be highly predictive of complicated pet bereavement (Field, Orsini, Gavish, & Packman, 2009; McNicholas & Collis, 1995; Wrobel & Dye, 2003). Specific areas of inquiry include the influence of attachment on the severity of grief responses (Field et al., 2009), the identification of circumstances associated with complicated pet loss experiences (McNicholas & Collis, 1995), and the relationship between the intensity of pet attachment and bereavement symptoms (Wrobel & Dye, 2003).

**Attachment bonds with pets.** In the context of human-pet relationships, the word *bond* is indicative of a relationship that is strong, trusting, and binding (Blackshaw, 1996). People often form attachment bonds with their pets, and many consider them integral to their family units (Beder, 2013; Brown, 2006). Further, the bonds between individuals and their pets can be as intense as person-to-person bonds (Beder, 2013; Brown et al., 2001; Clements et al., 2003), and some human-pet attachments may feel more significant to individuals than any of their other relational connections (Chur-Hansen, 2010).

Pets often fill significant roles in people's lives, and many pets serve as secure bases for their owners (McNicholas & Collis, 1995). Moreover, the essential factor that defines human-pet bonds as attachment bonds is when the presence of the pet provides the person with a sense

of comfort and security, where security denotes the experience of feeling relaxed and psychologically untroubled when a certain figure is close by (McNicholas & Collis, 1995). In addition, the simple proximity to one's pet can promote feelings of comfort and mitigate stress, in essence filling the safe haven function (Zilcha-Mano et al., 2012). As previously noted, the secure base and safe haven functions are two primary signs of secure attachment bonds (Zilcha-Mano et al., 2012).

Sometimes, pets are the primary contributors to bringing a sense of meaning and purpose to people's lives (Quackenbush & Graveline, 1985). As such, professional helpers need to understand that human-pet attachment bonds often provide a meaningful substitute for unhealthy (or absent) person-to-person attachment bonds (Field et al., 2009). Moreover, these clients may experience severe grief reactions when the bonds with their pets are severed (Sable, 2013). For example, women with tendencies to form insecure attachments with other people may find attachments with companion animals particularly compelling, as they offer an experience of security without the fear of abandonment one might experience with a human companion (Margolies, 1999). Similarly, women who do not have children in the home are more likely to establish a mother/child dynamic with a pet and to develop strong relational bonds with their surrogate children (Turner, 2001). Individuals who are divorced, widowed, do not have children, or have never been married also form more intense attachments with their pets compared to their counterparts (Brown, 2006; Gage & Holcomb, 1991).

Individuals' attachment styles can also influence the ways in which they relate to their pets (Zilcha-Mano et al., 2012). For example, pet owners with insecure ambivalent attachment styles (and associated relational anxiety) may particularly value the experiences their pets provide as a safe haven (Zilcha-Mano et al., 2012). Conversely, pet owners with insecure

avoidant attachment styles are more likely to perceive pets as unsupportive or unreliable when they don't meet the owners' security needs (Zilcha-Mano et al., 2012). Further, the distrust aroused by these unsatisfying experiences may lead avoidant pet owners to withdraw outward signs of affection from their pets (Zilcha-Mano et al., 2012).

McNicholas and Collis (1995) postulate that the broad range of responses to pet loss are directly linked to the types and degrees of emotional attachments experienced between people and their pets. Specifically, individuals with significant pet attachment bonds are more likely to experience intense grief reactions than individuals who are less attached to their pets (Archer & Winchester, 1994; Brown et al., 2001; Field et al., 2009; McNicholas & Collis, 1995). In addition, complicated grief reactions may occur when individuals' emotional needs are primarily fulfilled through their relationships with their pets or when they have previously experienced being rejected by human companions or society as a whole (Planchon & Templer, 1996).

Counselors should be also aware that the attachments formed between humans and their pets may sometimes be extremely unhealthy or pathological (Chur-Hansen, 2010; Hawn, 2015), particularly when individual become overly dependent on their pet and use the human-pet relationship as a proxy for more conventional human relationships (Carmack, 1991). Although the risk of suicide is typically deemed less significant in cases of pet loss (Butler & Degraff, 1996), clients with these types of unhealthy pet attachments may experience extreme grief responses that place them at increased risk (Archer & Winchester, 1994). Similarly, if clients have a history of depression, the loss of a pet may increase their risk for suicide, as some depressed individuals have reported that the presence of their pet served as a protective factor against taking suicidal action (Chur-Hansen, 2010).



Human-pet attachment bonds are implicated in several of the factors presented in Worden's mediators of mourning framework, such the role played by the pet (factor one), the nature of the relationship between the pet owner and the lost pet (factor two), and personality factors such as attachment style and ego strength (factor five). The following section addresses how social responses to pet loss (factor six) and perceptions about available social support influence individuals' pet loss experiences.

**Disenfranchised grief.** The importance of understanding the concept of *disenfranchised grief* cannot be overstated, as it is a highly prevalent experience among bereaved pet owners (Archer & Winchester, 1994). Disenfranchised grief refers to any loss that is discounted, minimized, or ignored by our society (Archer & Winchester, 1994; Beder, 2013; Brown et al., 2001; Cordaro, 2012; Doka, 1989; Durkin, 2009), that leads individuals to feel shame about their experiences and a general lack of safety and acceptance in sharing their grief with others (Chur-Hansen, 2010). Clients may also experience disenfranchised grief as a lack of permission to grieve the loss of their companion animals in the presence of friends, family, clinical professionals, or veterinary professionals (Planchon & Templer, 1996; Toray, 2004).

Social support for disenfranchised losses tends to be either limited or absent (Archer & Winchester, 1994), and individuals often struggle with finding support for pet loss, even among friends, family members, and counselors (Archer & Winchester, 1994; Bobier, 2011; Brown et al., 2001; Cordaro, 2012). This lack of social support seems to be particularly impactful for individuals who live alone, and this population of individuals is at greater risk for more intense grief reactions than those who live with others (Archer & Winchester, 1994).

Unsympathetic and dismissive responses to individuals' experiences may also exacerbate feelings of guilt and shame, causing clients to isolate from others and ultimately leading to a

complicated grief responses (Chur-Hansen, 2010). In addition, society often dictates what constitutes appropriate periods of bereavement (Bandini, 2015), and the period of time considered socially acceptable for disenfranchised losses (such as adult pet loss) is often grossly inadequate (Archer & Winchester, 1994). For example, there is no socially recognized normal grieving period for pet loss, nor is there an established period of time for when it is best to acquire a new pet (McNicholas & Collis, 1995).

Client' reactions to their losses may also be quite confusing to them, and they may feel shame or embarrassment that their losses are having such significant impacts on their lives, particularly when their losses are minimized by friends, family, and society (Beder, 2013; McNicholas & Collis, 1995; Quackebush & Graveline, 1985). The resulting sense of isolation makes it important for grieving pet owners to seek professional counseling, particularly when the difficulty of processing the death proves overwhelming to them (Quackebush & Graveline, 1985). Ultimately, the lack of social support inherent in the experience of disenfranchised grief can seriously interfere with the client's healing process (Beder, 2013).

Some research outcomes have suggested that access to social support at the time a loss occurs neither decreases the time needed to process and resolve the loss, nor facilitates the grief process in any particular way (W. Ströbe & Schut, 2001b; Wilsey & Shear, 2007). In the case of disenfranchised pet loss, the lack of social support experienced during the mourning period has been established as a key factor in the development of dysfunctional grief responses (Archer & Winchester, 1994; Beder, 2013; Brown et al., 2001; Cordaro, 2012; Durkin, 2009).

In review, the presence of supportive social relationships in clients' lives is associated with an increased ability to handle substantial life stressors and can act as a protective factor against less significant stressors (McNicholas & Collis, 1995). Moreover, the lack of a strong

social network is associated with complicated pet loss (McNicholas & Collis, 1995). Given the severe impact that disenfranchised grief can have on bereaved pet owners, it is not surprising that the role of disenfranchised grief is one of the most frequently discussed factors in the literature on pet bereavement (Chur-Hansen, 2010), making it an essential element of pet loss education. In addition to these significant social impacts, the circumstances surrounding the loss of a pet can be one of the most compelling issues associated with pet grief and complicated pet bereavement.

**Circumstances of pet loss.** When considering the impact of pet loss in clients' lives, it is essential that practitioners have an awareness of the broad spectrum of circumstances associated with pet loss, such as natural death (McCutcheon & Fleming, 2002), death by accident (Jordan et al., 1984; Sife, 2005), death that occurs as the result of a natural disaster (Lowe, Rhodes, Zwiebach, & Chan, 2009; Zotarelli, 2010), or traumatic death, such as when a pet is purposefully killed or injured (Adrian, Deliramich, & Frueh, 2009). Loss may also occur through disappearance (Clements et al., 2003; Jordan et al., 1984), a change in life circumstances, such as poor health (Carmack, 1991), financial difficulties (Hara, 2007), a change in housing (McNicholas & Collis, 1995), relationship changes (Jordan et al., 1984; Sable 2013), or theft (Clements et al., 2003).

Some losses, such as when a pet goes missing, are never fully resolved; these types of pet losses, known as *ambiguous losses*, are frequently linked to later emotional struggles (Humphrey, 2009). Moreover, pet owners who persist in hoping their pets will be found are at increased risk for grief complications (Chur-Hansen, 2010). In addition, concurrent losses or stressors, such as when an individual loses a job and can no longer afford to care for the pet, have been associated with aggravated grief responses (Chur-Hansen, 2010; McNicholas &

Collis, 1995). Unresolved grief from previous losses can also interfere with the grief integration process (Chur-Hansen, 2010).

Although human bereavement and pet loss share many similarities, the issue of euthanasia is frequently a primary factor in pet loss (Durkin, 2009), as well as a key predictor of complicated pet loss reactions (Gosse & Barnes, 1994). When euthanasia is part of the circumstances of pet loss, individuals are more likely to experience feelings of anger, guilt, and regret (Hall et al., 2004), particularly when financial circumstances were a deciding factor (Chur-Hansen, 2010). As such, counselors should be prepared to support clients in making decisions about euthanasia and to help them process the strong feelings of guilt that may accompany the decision to euthanize (Davis et al., 2003; Fernandez-Mehler et al., 2013; Quackenbush & Graveline, 1985; Turner, 1998).

Euthanasia is usually recommended by the veterinarian when medical interventions are not an option, whether because of excessive treatment costs, an inability to manage the pet's pain levels, or because there is no clear course of treatment available (Quackenbush & Graveline, 1985). When losses are associated with prolonged illnesses, it may be necessary for clinicians to help clients prepare for the anticipated loss (Fiske, 1995). In particular, it can be helpful to talk clients through logistical concerns ahead of time, including whether or not they want to be present for the procedure, if they want someone to be with them, and when and where they want the procedure to take place (Chur-Hansen, 2010).

Overall, understanding the circumstances associated with clients' losses may serve to help mental health practitioners target and address key bereavement issues, such as the deep sense of shame associated with euthanasia (Davis, Irwin, Richardson, & O'Brien-Malone, 2003) or the PTSD-like symptoms that may accompany a traumatic pet death (Hunt, Al-Awadi, &

Johnson, 2008). These key findings align with three explicit factors from Worden's mediators of mourning framework: (a) the circumstances of the loss (factor 3), (b) the individual's history of loss (factor 4), and (c) the presence of concurrent stressors (factor 7).

This section discussed the three factors of pet loss that are most likely implicated in complicated pet bereavement (attachment bonds with pets, disenfranchised grief, and pet loss circumstances). In addition, this section illustrated how Worden's framework of mourning can be adapted to issues central to pet bereavement. In the following section, additional concerns related to complicated pet loss are addressed.

### **Complicated Pet Loss**

Whether mourning the loss of a person or a pet, the process of bereavement is a normal human experience (Neimeyer & Currier, 2009). Moreover, a majority of bereaved pet owners are able to process and resolve their grief experiences without professional facilitation (Quackenbush & Graveline, 1985). However, between 5%-12% of bereaved pet owners experience significant psychological disruptions after the loss of their pets (Adrian et al., 2009). Although this figure is notably lower than the nearly 20% of individuals who experience complicated grief following a human loss (Neimeyer & Currier, 2009), it seems clear that complicated pet loss will be an issue for some bereaved pet owners. However, despite the high degree of comorbidity experienced between complicated pet losses and mental health disorders such as depression, anxiety, and PTSD (Archer & Winchester, 1994), it is essential that practitioners be careful not to mislabel an expected pet loss reaction as a pathological disorder (Adrian et al., 2009; Baier & Buechsel, 2012).

Some of the grief reactions associated with complicated pet loss responses include an impulse to search for the lost pet (denial response), debilitating feelings of depression and

anxiety, avoiding reminders or thoughts about the loss, and pretending the pet is in the immediate vicinity as a strategy for minimizing feelings of grief (Archer & Winchester, 1994). Common pet loss experiences, such as having one's loss dismissed by others or perceiving an overall lack of social support in one's life, have been associated with both disenfranchised pet loss and complicated pet bereavement (Turner, 2003).

The period of mourning associated with the loss of an animal companion is often longer than with a person (Hunt & Padilla, 2006), and it is not unusual for clients to experience persistent subclinical symptoms of sadness and grief for six months or longer after losing a pet (Adrian et al., 2009). More specifically, the acute phase of pet loss can persist for up to two months, and uncomplicated pet grief can last from six months up to a year, with an average bereavement period being 10 months (Beder, 2013). The length of time that symptoms persist as well as the severity of the presenting symptoms are key indicators of the degree of grief intensity experienced by individuals (Wrobel & Dye, 2003).

Additional variables that may increase an individual's predisposition to complicated pet grief include: an absence of family support, a lack of spiritual beliefs, being female versus male, having a parental or spousal connection to the deceased, and having a prior history of an affective disorder (Chiu et al., 2010). Other significant risk factors for complicated pet grief include being elderly, living alone, or assigning human attributes to a pet (Fiske, 1995). Further, pet owners who live alone and whose sole companion was the lost pet may need professional support (Fiske, 1995). Traumatic life events, such as an unexpected pet death, can also be particularly devastating, as they fracture an individual's perception of reality, and promote feelings of instability, impotence, and an overall lack of safety (Cicchetti, 2010). Moreover, the

risk for complicated pet grief increases when the pet death itself occurred under traumatic conditions (Janssen, 2016).

Individuals who had satisfying relationships, established routines, and adequate levels of social and emotional functioning before the loss occurred are the least likely to experience notable disruption to these constructs after the loss. However, individuals who also experienced significant life stressors prior to their losses are more likely to experience disruptions in these key areas of functioning, given the increased pressure on their already tapped coping resources. Further, as the experience of stress is cumulative in nature, individuals who experience concurrent life stressors with their bereavement losses are not only at an increased risk for anxiety, depression, and stress-based physical responses, but are also likely to need professional support to address and mitigate the effects of both pre- and post-loss stressors (McNicholas & Collis, 1995).

It is also important for clinicians to investigate the role of prior losses, as unresolved grief may be triggered by the loss of a pet, reawakening significant emotional wounds from the past that may serve to further complicate the loss (Chur-Hansen, 2010; Donohue, 2005; Heikkinen, 1979). Clinicians should also consider that shorter pet life spans might mean that individuals have experienced multiple pet losses during their lives (Bobier, 2011; Corr, 2004). If an individual has experienced a prior pet loss, it might be beneficial to review what helped them get through the prior loss, in order to rebuild upon those personal strengths (Bobier, 2011).

In review, several key findings emerged regarding complicated pet loss. To begin with, individuals who are at high risk for complicated pet bereavement tend to have pets that play significant, key roles in their lives, and with whom they experience substantial emotional dependence (McNicholas & Collis, 1995). Frequently, these individuals have a dearth of human

relationships, and may have depended on their pets to enhance their social connections (McNicholas & Collis, 1995). Further, these high-risk individuals are likely to experience significant disruptions to multiple life domains (cognitive, emotional, and social) and require professional intervention in order to adjust to their new life circumstances (McNicholas & Collis, 1995). Although this portion of the literature discussed the various factors that should be considered when evaluating a client's experience of pet loss, the following assessment instruments may support mental health professionals in gathering information about pet loss variables, particularly those associated with pet attachments.

### **Pet Loss Assessment Instruments**

Measures that may be particularly relevant to pet loss assessment include the Pet Loss Questionnaire (Archer & Winchester, 1994), the Pet Attachment Questionnaire (Zilcha-Mano, Mikulincer, & Shaver, 2011), the Dog Attachment Questionnaire (Archer & Ireland, 2011), the Pet Death Survey (Wrobel & Dye, 2003), the Pet Bereavement Questionnaire (Hunt & Padilla, 2006), the Comfort from Companion Animals Scale (Zasloff, 1996), and the Lexington Attachment to Pets Scale (Baucom, 2007; Johnson, Garrity, & Stallones, 1992). Specifically, the Dog Attachment Questionnaire (Archer & Ireland, 2011) provides information on the strength of the individual's attachment bond with their pet and evaluates the degree to which the person relied on the pet as a secure base, invested in a caregiving role with their pet, and perceived separation anxiety, given the loss of the pet. The Pet Attachment Survey provides information on the human-pet attachment bond, with attention on the physical interactions (such as petting) and degree of emotional intimacy (Wrobel & Dye, 2003).

The key finding in this section of the literature is that numerous assessment instruments are available to gather data on a variety of pet loss variables. These instruments can supplement



the assessment data collected in the initial client interviews. Awareness of the most salient considerations when conducting the initial pet loss assessment sessions can yield vital information for pet loss counselors in terms of diagnosis, risk assessment, and treatment planning.

### **Interviewing the Bereaved Pet Owner**

The literature made numerous suggestions for how mental health professionals should engage bereaved pet owners. Overall, it is essential that counselors engage pet loss clients with empathy, sensitivity, and respect (Quackenbush & Graveline, 1985) and normalize any feelings of grief they are experiencing (Alstat, 1997; Baier & Buechsel, 2012; Beder 2013; Turner, 2003). As with traditional grief counseling, basic counseling skills, such as reflective listening and empathy, are important aspects of pet loss support (Cohen, 2008). In the initial interview with bereaved pet owners, counselors should prompt clients to discuss their losses by asking questions about their pets (pet's name, appearance, and length of ownership), the nature of their relationship with their pets (role of pets in their lives), the circumstances of their losses, how they felt when their losses occurred, and what they feel would best support them in coping with their losses (Davis et al., 2003).

Providing clients with information about normal grief responses is another important element of pet loss counseling (Chur-Hansen, 2010). In particular, counselors need to educate clients about the somatic, cognitive, and affective responses that may occur as part of normal grief responses (Chur-Hansen, 2010). Clients may be particularly reassured by the knowledge that it is completely normal to hear pet footsteps, barks, or meows, or to have a sense of their pet's presence during the initial period of loss (Chur-Hansen, 2010).

Clinicians should also help bereaved pet owners explore how their animal companions shaped their life experiences (Quackenbush & Graveline, 1985). Encouraging clients to share photos of their pets and to recount favorite stories can be useful in evoking clients' loss narratives (Beder, 2013). If clients seem hesitant to discuss their losses, counselors may need to encourage them to talk about their pets and offer explicit permission for them to express their feelings of grief, particularly if they have felt marginalized in their grief processes (McNicholas & Collis, 1995; Sable, 1995; Sharkin & Knox, 2003). The simple process of acknowledging their losses may be particularly meaningful and validating to pet loss clients (Sharkin & Knox, 2003).

In general, all pet loss clients are likely to benefit from clinicians attending to three key issues: (a) providing support to offset the impact of social deficits, (b) providing clients with a safe, receptive space for verbalizing their thoughts and feelings about the loss, and (c) supporting clients with decision-making and other needed problem-solving (Turner, 2003). Ultimately, the goal of pet loss counseling is to help bereaved clients construct a new life framework that allows them to understand and integrate their losses so that they can move forwards towards meaningful lives without their pets (Cicchetti, 2010).

This section of the literature yielded key findings about strategies for developing working alliances with bereaved pet owners during initial assessment sessions. In the following section, additional recommendations for providing support to bereaved pet owners are discussed.

### **Pet Loss Support Model**

Although the literature review provided numerous references regarding general supports for bereaved pet owners, there was little mentioned about comprehensive support models. However, Quackenbush and Graveline's (1985) three-part system of grief support seems to

consolidate numerous findings about pet loss support into a unified framework for pet loss assessment and support. Interestingly, despite being developed over 30 years ago, this model has been extensively cited in the pet loss literature (Carmack, 1991; Clements et al., 2003; Dunn, Mehler, & Greenberg, 2005; Hunt et al., 2008; Turner, 2003).

The Quackenbush and Graveline (1985) pet loss support model is composed of three, multi-part aspects of clinical concern and intervention. First, clinicians provide clients with death education that covers (a) what they can expect to feel during the grieving process, (b) symptoms that indicate maladaptive grief responses, (c) their beliefs about death, and (d) how they have coped with death in the past. Second, clinician help clients to identify support resources, including people who understand the deep feelings associated with their losses and who are also willing to listen to their bereavement narratives. Third, clinicians support clients in developing coping skills and strategies.

The key finding in this section was the introduction of a pet loss support model. This model could be used to provide direction and intention to treatment planning and the structure of counseling sessions. Once assessment data has been collected and an initial therapeutic connection has been established, mental health professionals should be prepared to offer intervention strategies.

### **Pet Loss Interventions**

Being familiar with both the general spectrum of issues related to pet loss, as well as the specific variables associated with a client's experience of pet loss, will allow clinicians to choose the most appropriate intervention strategies (Beder, 2013; Donohue, 2005). In addition, when counseling a grieving client, it is important for counselors to provide interventions that both address immediate bereavement needs (Heikkinen, 1979) and serve to facilitate an overall

process of growth in clients (Altmaier, 2011). Daneker and Aiello (2015) suggest that counselors direct their assessment and intervention efforts towards addressing the elements in the grieving process that have their clients feeling stuck. However, mental health professionals should avoid making suggestions about replacing lost animals with new animal companions or giving any advice that is primarily intended to minimize the experiences of clients (Toray, 2004). These strategies may encourage individuals to suppress their emotional experiences, which can interrupt the grieving process (Toray, 2004).

When working with bereavement issues, mental health professionals must also be prepared to address clients' religious beliefs and view on spirituality (Evans, 1997; Thurston-Dyer & Hagedorn, 2013). Many clients find comfort from *positive religious coping* strategies such as seeking support from faith communities, prayer, and religious beliefs while others who expect to feel comforted from these coping mechanisms are not (Pearlman et al, 2014). These latter individuals may instead experience *religious struggle*, a negative version of religious coping, where individuals feel betrayed or abandoned by God, have an overall crisis of faith, or believe that life is meaningless without the presence of their loved one (Pearlman et al., 2014).

Another area of clinical concern associated with loss and spirituality is that of *post-traumatic growth*, a term used to describe the positive shifts that may result from clients' struggles with significant losses, such as bereavement (Pearlman et al., 2014). Although there is limited literature available on post-traumatic growth, certain factors have been explored as possible predictors for this type of post-loss response, including the client's age, the quality of their social support system, the amount of time that has passed since the loss occurred, their religious and spiritual beliefs, and their use of active cognitive coping practices (Michael & Cooper, 2013). Of these factors, adequate social support is an essential promoter of growth

outcomes and having a spiritual or religious belief system typically facilitates positive loss outcomes (Michael & Cooper, 2013). In addition, cognitive problem-solving strategies such as looking for benefits, making meaning from the loss, and reframing one's life context can be helpful in promoting feelings of growth following a loss. The time frame for seeing bereaved clients is also important as clients who receive support during the acute loss period may be more open to certain positive mindsets, including an increase in interpersonal relationships and an increased appreciation for life (Michael & Cooper, 2013).

Five types of personal experiences are indicative of posttraumatic growth: (a) a newly felt sense of life possibilities, (b) a positive shift in interpersonal relationships, (c) an increased awareness of personal resilience, (d) a deeper sense of gratitude for life, and (e) a notable shift in spiritual and religious perspective (Pearlman et al., 2014). When dealing with the possibility of posttraumatic growth, mental health professionals must understand that there is a societal bias for celebrating individuals who rise above tragedy and a client's social network may unconsciously discourage any sort of negative distress response the client may be having by strongly encouraging self-reports that are positive in nature and responding negatively to those that are not (Pearlman et al., 2014). Similarly, clinicians must be careful to avoid expectations of posttraumatic growth in their clients, as the inability to find a silver lining of some sort in their loss experience may cause clients in this situation to feel as if there is something wrong with the way they grieve (Michael & Cooper, 2013; Pearlman et al., 2014).

Counselors may also need to be familiar with clients' spiritual beliefs in order to support them in developing a grief ritual to commemorate their pet (McNicholas & Collis, 1995). Given the lack of specific bereavement rituals socially mandated to acknowledge the loss of pets (McNicholas & Collis, 1995), creating personalized grief rituals can serve to explicitly recognize

the passing of their pets and help clients move towards closure (Beder, 2013; Brown et al., 2001; Gage & Holcomb, 1991; McNicholas & Collis, 1995; Quackenbush & Graveline, 1995).

Although there is concern by some that introducing the topic of religion into therapeutic sessions would be detrimental to clients, the lack of professional training in this area could be a primary reason why many counselors are uncomfortable incorporating issues of spirituality into the counseling process (Evans, 1997). In addition, despite the lack of clinical imperatives to engage clients about spiritual or religious matters, clinicians who avoid discussing faith issues with their bereaved clients may be missing out on key opportunities for providing loss support and facilitating growth outcomes (Bray, 2011).

When disenfranchised grief is a factor, counselor empathy can be a significant intervention on its own (Turner, 2003). In addition, disenfranchised grievers may benefit from pet loss support groups, particularly during the initial, acute phase of grief (Carmack, 1991; Dunn et al., 2005; Ross & Baron-Sorensen, 2007). Support groups provide several key benefits for disenfranchised grievers: they help normalize and legitimize the experience of pet loss, provide a safe container for individuals to express their feelings, and allow individuals to share their stories and coping strategies (Beder, 2013; Ross & Baron-Sorensen, 2007). Pet loss groups may also create an opportunity for social bonding between individuals based on their mutual losses and shared understanding; these types of friendships may be particularly beneficial to elderly individuals whose pets served as primary sources of companionship (Beder, 2013). Similarly, participation in online groups, communities, or helplines may be therapeutic for individuals experiencing disenfranchised loss (Packman et al., 2014) by providing individuals with feelings of acceptance and a sense of normalcy regarding their bereavement experiences.

CBT can be helpful in addressing feelings of anger, guilt, or self-blame that may arise after euthanizing a pet (Ross & Baron-Sorensen, 2007; Turner, 2003). When pet losses occur under traumatic circumstances, interventions such as hypnotherapy and eye movement desensitization and reprocessing (EMDR) can also be beneficial (Ross & Baron-Sorensen, 2007). In addition, when individuals experience traumatic pet losses, which are also characterized as complicated losses, clinicians may want to consider the use of technology-based interventions that are delivered via the Internet, as interventions for complicated grief have proven beneficial when delivered in this format (Sofka, Cupit, & Gilbert, 2012).

Clinicians may also want to be familiar with the way pet loss is addressed in the self-help literature, as clients experiencing normative pet loss responses may benefit from the use of self-help materials (Cordaro, 2012; Worden, 2002). Moreover, given the notable lack of resources that specifically address pet loss, it seems important for counselors to maintain a current listing of community and online resources (Freedman et al., 2014), particularly as literature that describes common pet loss responses can reassure clients that their own bereavement responses are neither atypical or pathological (McNicholas & Collis, 1995). To this end, Chohan (2001) suggests three online resources for pet bereavement. First, the *In Memory of Pets* website ([www.in-memory-of-pets.com](http://www.in-memory-of-pets.com)) offers ongoing, free pet loss support. Second, the *Lightning Strike* website ([www.lightning-strike.com](http://www.lightning-strike.com)) offers pet support through live chat and resource referrals. Third, *The Association for Pet Loss and Bereavement* website ([www.aplb.org](http://www.aplb.org)) offers an extensive variety of support options, including scheduled online chat groups for both pet loss and anticipatory bereavement. Connecting clients with self-help resources can be particularly helpful for clients who need support but are uncomfortable with more formal interventions such as group work or individual therapy (Cordaro, 2012; Worden, 2002).

In sum, this section of the literature review yielded numerous key findings that address what mental health professionals need to know about assessment, diagnosis, and treatment of grief related to pet loss. To begin with, in order to fully understand the variety of impacts that losing a pet might have in the lives of their adult clients, mental health professionals need to understand the significance of human-pet relationships, including the prevalence of pets in American culture and the key social roles that pets fill in their owners' lives (Beder, 2013; Donohue, 2005). In conceptualizing the process of pet bereavement, clinicians should also be aware that, like human-human losses, human-pet losses affect pet owners across multiple life domains, and may be wholly devastating experiences for some clients (Donohue, 2005). Similarly, the seven types of variables identified as key grief factors in human-human grief were also present in human-pet losses. Moreover, key assessment factors used to help identify complicated human-human losses, such as the degree of symptom severity, the time frame/duration of symptoms, and the pervasiveness of dysfunction, were also be used to identify complicated pet bereavement. However, despite the noted similarities, some grief issues were more specific to pet loss. For example, when dealing with pet bereavement, clinicians must be familiar with three factors that have been identified as most likely to promote complicated pet responses: (a) the degree of attachment with the pet, (b) the degree of social acceptance and available support after the loss of the pet, and (c) the circumstances surrounding the loss of the pet. Being able to distinguish uncomplicated pet grief from complicated pet grief was identified as a key clinical skill in pet loss counseling (McNicholas & Collis, 1995). To that end, an awareness of the risk factors associated with complicated pet bereavement can help clinicians identify and predict complicated pet bereavement. In addition, mental health professionals may want to use assessment instruments to collect data about identified pet loss variables in order to



better determine the type of loss reactions client are experiencing. In addition, a pet loss support model can be useful in providing a conceptualization of pet loss and a framework for both assessment and support. Finally, in terms of interventions, clinicians should be familiar with strategies that have been identified in the pet loss literature as being particularly beneficial for individuals experiencing adult pet loss.

### **Intended Audience**

According to the findings from the literature review, many mental health professionals have limited training or clinical experience working with either human or pet bereavement (Cicchetti, 2010; Doughty-Horn et al., 2013). As such, the literature identified the need for an increased population of mental health professionals who understand the importance of human-pet attachments and the issues associated with pet bereavement (Toray, 2004; Turner, 1997). This need was linked to insufficient training on the topic of grief and bereavement counseling in professional training programs (Doughty-Horn et al., 2013; Pomeroy & Garcia, 2009) as well as the absence of a CACREP curricular standard for grief education (CACREP, 2015; Doughty-Horn et al., 2013).

In order to address this identified professional training goal, mental health clinicians need to have access to information that addresses the essential elements of clinical concern related to grief counseling and adult pet loss. Key professional associations, including the American Counseling Association (ACA), the American School Counseling Association (ASCA), the American Association for Marriage and Family Therapy (AAMFT), and the National Association of Social Workers (NASW), all utilize online training resources, such as podcasts and webinars, to provide continuing education opportunities to their members. Thus, it seems

clear that using electronic media to deliver training content is widely accepted in the mental health professions.

In terms of current available training content, the aforementioned professional associations provide limited training addressing the broader topic of grief counseling, and a search for the terms, “pet loss” and “pet bereavement,” yielded zero online training resources on either the AAMFT ([www.aamft.org](http://www.aamft.org)) or NASW ([www.socialworkers.org](http://www.socialworkers.org)) websites. The ACA website ([www.counseling.org](http://www.counseling.org)) offers 35 training units on various facets of grief, yet none specifically focused on pet loss. Similarly, while the ASCA website ([www.schoolcounselor.org](http://www.schoolcounselor.org)) recently launched a new certification module called, “Grief and Loss Specialist,” none of the curricular materials specifically focus on the topic of pet loss. As these national mental health associations have failed to address the need for professional online training for pet loss, an application piece has been designed to address this training gap. Following is a justification for the type of format used in the application piece along with a description of the delivery system.

### **Application**

Although asynchronous training methods, such as webinars and podcasts, have been embraced by professional associations, there is concern that distance-based learning that is delivered entirely online may be less effective than learning methods that include face-to-face interactions (Booth, Carroll, Papaioannou, Sutton, & Wong, 2009). However, the increased availability and accessibility to educational resources provided by online learning tools along with the affordability of web-based education offsets these concerns for some (Booth et al., 2009; Yates, 2014). Moreover, online education delivered in an asynchronous format can be as effective for meeting learning objectives as classroom-based learning (Yates, 2014). As such, the application piece will be delivered online using asynchronous technology methods.

The application piece is formatted as an educational webinar, composed of informational slides along with an audio discussion of the content. The slide portion of the webinar is presented in Appendix A. In addition, the narrative content that accompanies the slides in the webinar is included in Appendix A. The 50-minute length of the webinar is designed to cover essential clinical concepts while requiring a modest time investment from busy mental health professionals. In addition, this time frame is aligned with time requirements for continuing education (CE) credits.

The webinar content directly addresses the research question by identifying and discussing the key findings of this literature review. These key findings identified what clinicians need to know about grief work in order to have an adequate clinical foundation for understanding and implementing the concerns associated with pet loss counseling. The key findings also included specific recommendations related to the assessment, diagnosis, and treatment of concerns associated with adults who experience pet loss. The asynchronous, online format allows these key findings to be disseminated to a variety of mental health professionals, including counselors, school counselors, marriage and family therapists, and social workers.

### **Conclusion**

A comprehensive review of the literature identified a significant training gap in the areas of grief and pet loss counseling for mental health professionals. In order to address this training need, the research question called for an investigation of the clinical issues associated with the assessment and treatment of adult pet loss. The resulting investigation utilized both empirical and current research to determine the training points that are essential in educating mental health professionals about pet loss with adult clients

First, the literature identified numerous learning targets associated with grief counseling training. These included an understanding of the role of attachment in bereavement, the components of grief, and the major theoretical perspectives related to grief counseling. In addition, the literature discussed the variables that influence grief responses, the issues associated with complicated grief, how the DSM distinguishes bereavement from other mental health concerns, and relevant data collection instruments. The literature also outlined techniques and interventions for addressing both uncomplicated and complicated grief.

Next, the literature identified numerous learning targets specific to training for pet loss counseling. These included the significance of human-pet relationships, the components of pet loss, and pet loss models. Several essential pet loss factors were also named, including the influence of attachment bonds with pets, the experience of disenfranchised grief, and the circumstances associated with the loss. Issues associated with complicated pet loss were delineated along with assessment instruments that measure key pet loss variables. In addition, a model for pet loss support was discussed as well as recommendations for interacting with bereaved pet owners. Finally, the literature validated a variety of pet loss interventions.

In sum, the literature review indicated that mental health professionals should acquire essential assessment and treatment skills to address the needs of bereaved clients (Cicchetti, 2010), particularly those experiencing pet loss (Turner, 2003). In order to perform these counseling tasks effectively and compassionately, mental health professionals need specific training on clinical issues associated with human-pet attachment bonds and pet bereavement (Toray, 2004). The literature review identified two key areas of clinical concern essential to mental health training for adult pet loss. These core areas of inquiry included an introduction to grief counseling and a detailed accounting of issues relevant to pet loss counseling. The

overview of grief concepts and methods was intended to create a solid foundation in grief theory that would facilitate the reader's understanding of what makes human-pet losses both similar and different from human-human losses.

Ultimately, a comprehensive review of the literature yielded numerous key findings specific to the question of what mental health professionals need to know in order to competently assess and treat issues associated with adult pet loss. Based on these findings, this research project distilled the identified areas of clinical concern into an educational webinar for mental health professionals. After reviewing this webinar, professionals should be prepared to assess and support adult clients experiencing pet loss, thus meeting the target criteria of the research question.

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## List of Appendices

	Page
Appendix A: Application .....	90
Figure A1: Introduction to Webinar .....	91
Figure A2: Self-Reflection Exercise 1 .....	93
Figure A3: An Overview of Grief Counseling .....	95
Figure A4: Attachment Theory and Grief.....	97
Figure A5: Components of Grief .....	99
Figure A6: Grief Theories and Models.....	101
Figure A7: Phase Model vs Task Model.....	103
Figure A8: Self-Reflection Exercise 2.....	105
Figure A9: Grief Variables .....	107
Figure A10: Understanding Complicated Grief.....	109
Figure A11: Risk Factors for Complicated Grief .....	111
Figure A12: Clinical Grief Diagnosis I.....	113
Figure A13: Clinical Grief Diagnosis II .....	115
Figure A14: Assessment Instruments .....	117
Figure A15: Interventions for Uncomplicated Grief .....	119
Figure A16: Self-Reflection Exercise 3 .....	121
Figure A17: Counselor Self-Awareness .....	123
Figure A18: Interventions for Complicated Grief: IPT .....	125
Figure A19: Interventions for Complicated Grief: CBT.....	127
Figure A20: Self-Reflection Exercise 4 .....	129



Figure A21: Pet Loss Counseling .....	131
Figure A22: Human-Pet Relationships I.....	133
Figure A23: Human-Pet Relationships II .....	135
Figure A24: Components of Pet Loss.....	137
Figure A25: Pet Loss Models .....	139
Figure A26: Self-Reflection Exercise 5 .....	141
Figure A27: Essential Pet Loss Factors .....	143
Figure A28: Self-Reflection Exercise 6 .....	145
Figure A29: Attachment Bonds with Pets .....	147
Figure A30: Self-Reflection Exercise 7 .....	150
Figure A31: Disenfranchised Grief.....	153
Figure A32: Circumstances of Pet Loss.....	154
Figure A33: Self-Reflection Exercise 8 .....	156
Figure A34: Pet Euthanasia .....	158
Figure A35: Complicated Pet Loss .....	160
Figure A36: Risk Factors for Complicated Pet Loss .....	162
Figure A37: Pet Loss Assessment Instruments.....	164
Figure A38: Interviewing the Pet Loss Client .....	166
Figure A39: Pet Loss Support Model .....	168
Figure A40: Pet Loss Interventions I.....	170
Figure A41: Pet Loss Interventions II.....	172
Figure A42: Self-Help Resources .....	174
Figure A43: Closings .....	176

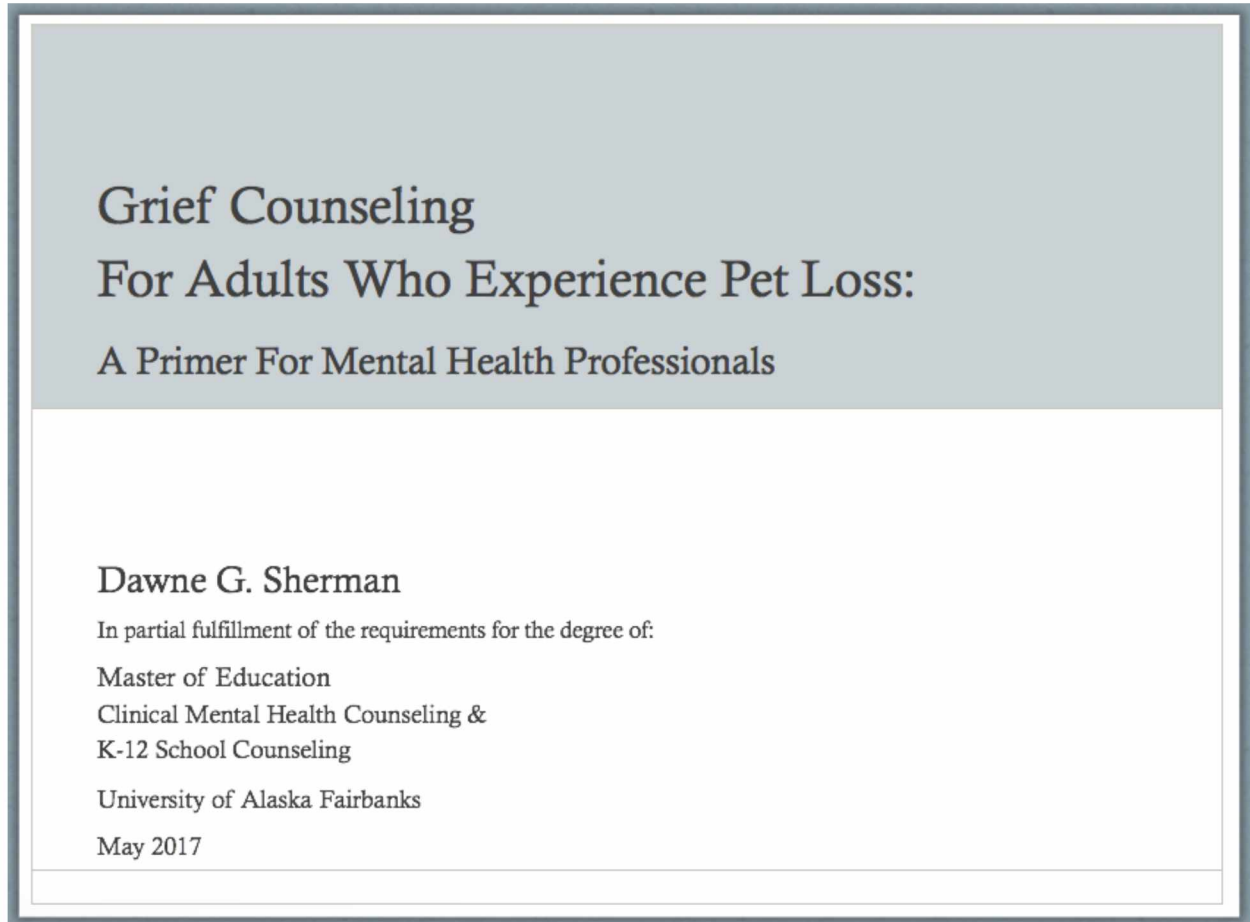
Conclusion .....	178
Application References .....	179
Appendix B: Proposed Diagnostic Criteria for Persistent Complex Bereavement Disorder.....	191

## Appendix A

### **Application**

A comprehensive review of the literature found that mental health professionals receive inadequate training regarding both grief and pet loss counseling (Doughty-Horn et al., 2013; Sharkin & Bahrack, 1990; Sharkin & Knox, 2003). In addition, the literature supported the use of web-based tools for educational purposes (Sofka et al., 2012). Therefore, based on insights extracted from the literature, an educational webinar was developed that highlights the core issues associated with counseling adults who are experiencing pet loss. The following pages feature screenshots of the slide portion of the webinar along with written narratives that detail the spoken content intended to accompany each slide.

**Figure A1: Introduction to Webinar**



**Narrative for Figure A1: Introduction to Webinar**

Welcome to *Grief Counseling for Adults Who Experience Pet Loss: A Primer for Mental Health Professionals*. My name is Dawne Sherman and I created this webinar to educate clinicians about the core concerns related to pet loss with adult clients. In particular, this webinar will cover what mental health professionals need to know in order to provide professional support services to adult clients who have already experienced, or who are about to experience, the loss of a beloved pet. Throughout this webinar, a series of self-reflection exercises will help viewers identify their current attitudes towards pet loss as well as any knowledge deficits they have related to pet loss counseling. By the end of this webinar, viewers should be familiar with the key factors associated with adult pet loss and understand how these factors can inform diagnosis, risk assessment, and treatment planning. Overall, viewers should have a better understanding of the profound sense of loss individuals might experience following a companion animal's death and be better prepared to respond to clients in an appropriate and compassionate manner.

**Figure A2: Self-Reflection Exercise 1**

## Self-Reflection Exercise 1

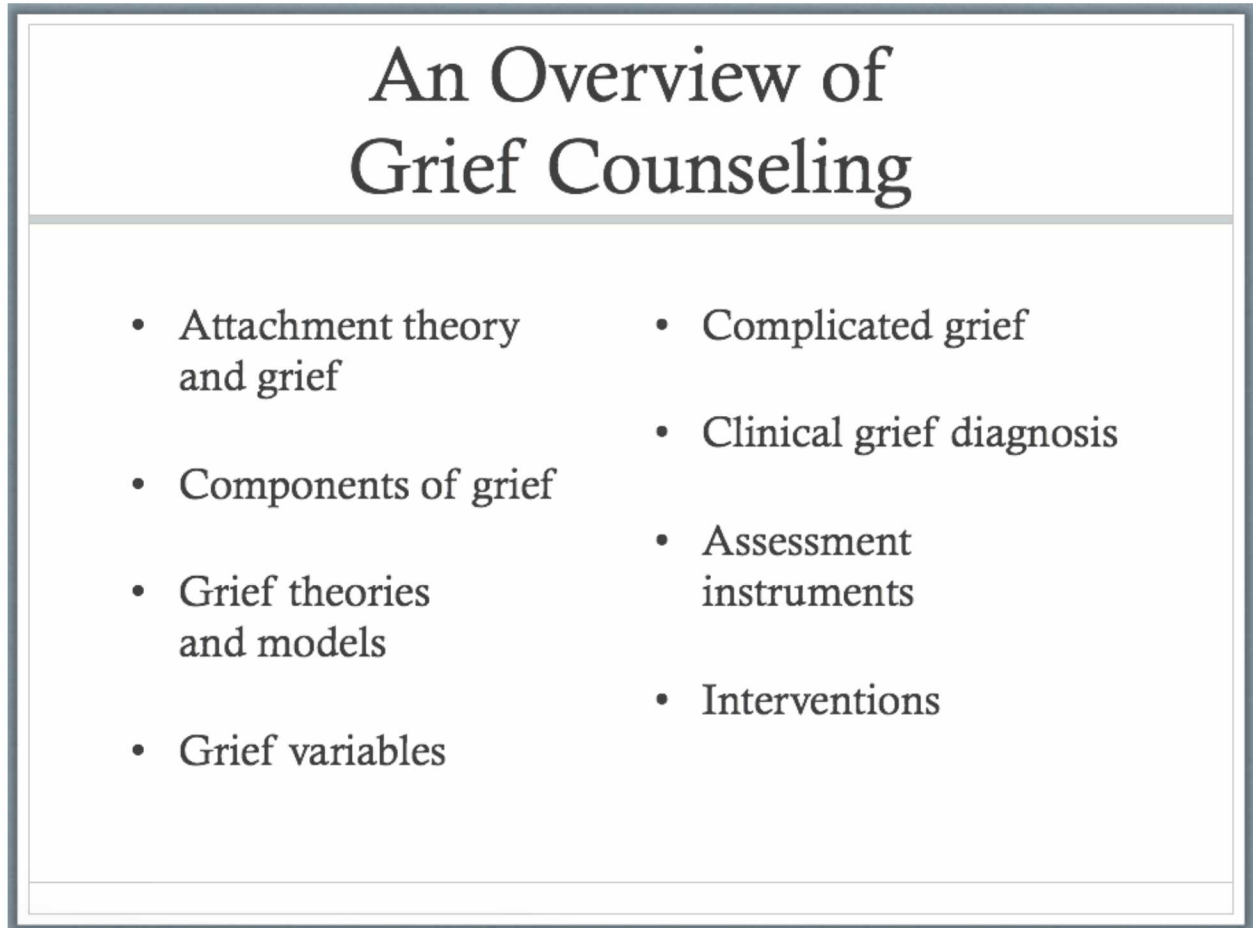
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- As a mental health professional, how do you respond to a grieving adult client?

**Narrative for Figure A2: Self-Examination Exercise 1**

The first self-examination exercise poses the following question: “As a mental health professional, how do you respond to a grieving adult client?” As you think about this question, consider the following scenario. An ongoing client tells you their spouse died last week. In what ways do you imagine this situation would impact your client? How long do you think the grieving process might last? On a scale of one to ten, how serious does this issue seem?

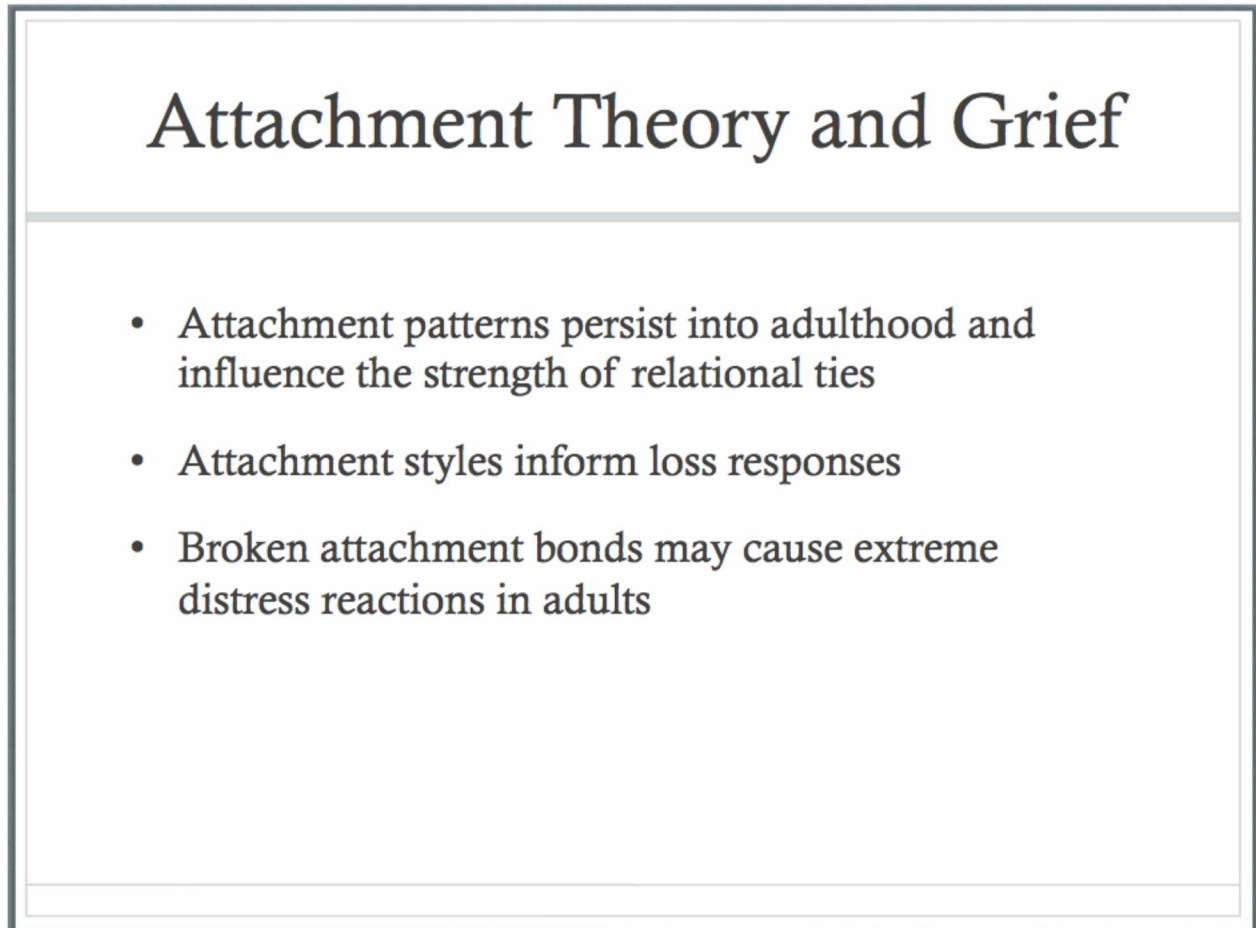
Now, imagine a slightly different scenario. Your client comes in and tells you that their dog or cat died last week. On a scale of one to ten, how serious does this issue seem to you? What period of grieving seems normal to you for this type of loss? Do you think this loss will have much of an impact on your client?

**Figure A3: An Overview of Grief Counseling**



**Narrative for Figure A3: An Overview of Grief Counseling**

That exercise was intended to have you to consider your current perceptions about human loss versus pet loss. Moving forward, this webinar will provide a brief introduction to grief counseling as a broader context for the subject of pet loss counseling. The elements included in this introduction constitute the basic issues identified in the literature as key learning points for mental health professionals counseling bereaved adults.

**Figure A4: Attachment Theory and Grief**

**Narrative for Figure A4: Attachment Theory and Grief**

The first learning point addresses the relationship between attachment and grief.

Bowlby's attachment theory suggests that human infants form attachment bonds with parents or other essential caregivers as a part of a larger security-seeking process. Any disruption in these bonds creates feelings of distress and elicits behaviors from infants intended to re-establish disrupted connections. As adults, these same types of innate attachment instincts motivate individuals to form and maintain relational bonds with others and to seek support through these bonds during times of distress.

Attachment patterns also influence the overall psychological well-being of adults, including how they manage stress and function in social situations. In addition, attachment patterns inform the nature of adult relationships and the strength of relational ties between bereaved individuals and their lost loved ones. When attachment bonds are severed through permanent separation or death, it is a natural response for individuals to grieve these lost connections.

References: Archer & Ireland, 2011; Hetherington, Parke, Gauvain, & Locke, 2006; Jeffreys, 2005; Pomeroy & Garcia, 2009; Santrock, 2009; Shear & Mulhare, 2008

**Figure A5: Components of Grief**

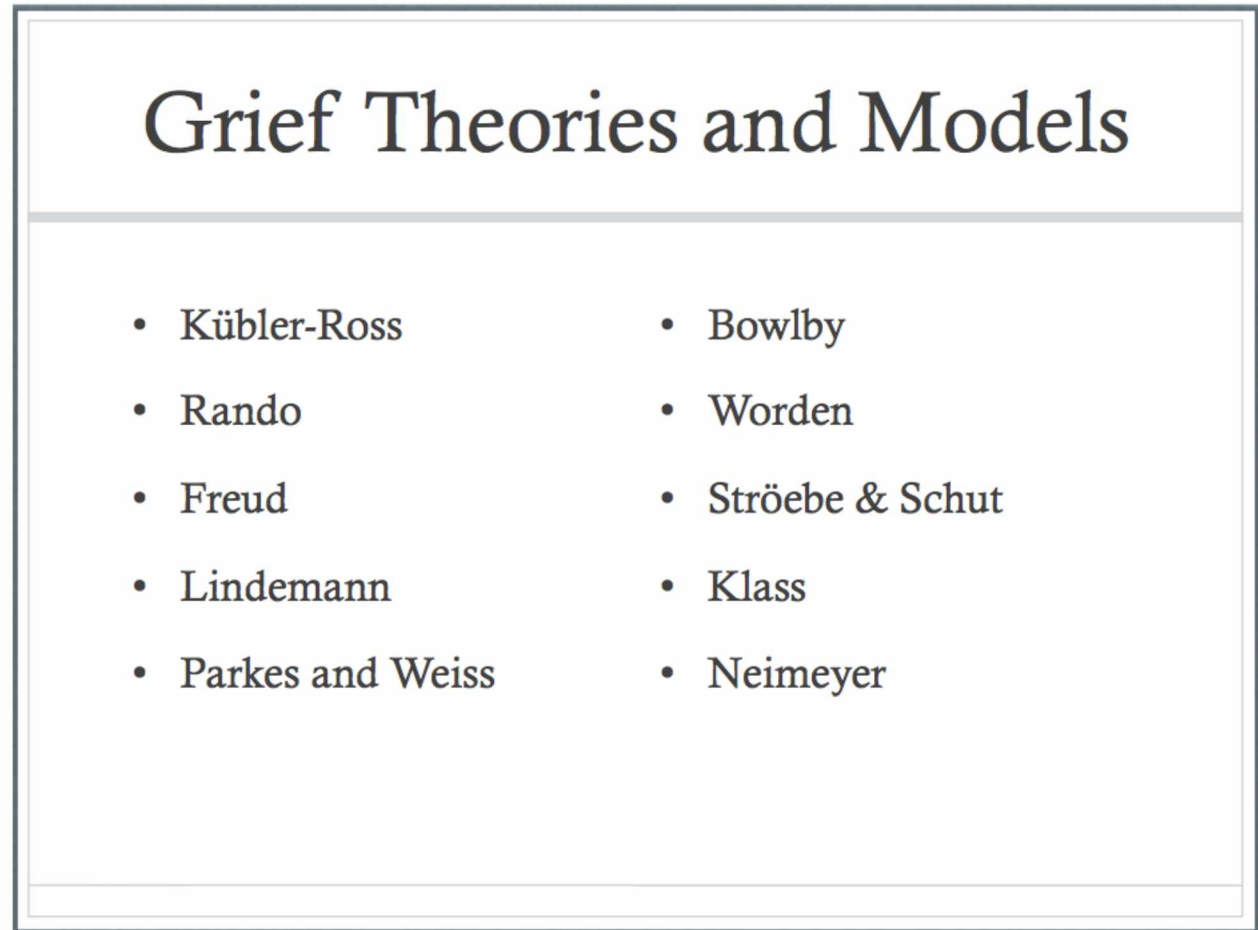
**Narrative for Figure A5: Components of Grief**

The next learning point addresses the various components of grief, which can impact individuals on many levels, including physical, cognitive, emotional, social, and spiritual. Although individuals will experience certain types of symptoms more than others, be alert to the normal grief responses that follow.

For example, in terms of physical complaints, grieving clients may experience stomach pain and nausea, changes in appetite and weight, sleep disturbances, increased colds, or a lack of sexual desire. Bereaved adults may also experience any number of cognitive challenges including difficulty concentrating, memory loss, confusion, slow response times, or a sense of perceived helplessness and futility. The emotional impact of grief may include feelings of sadness, anger, fear, guilt, or shame. Clinicians should be prepared for clients to direct grief-related anger towards them as a means of exploring whether or not the space is truly safe for expressing their pain.

In terms of social impacts, people respond to learning about grief in different ways. Some offer unsolicited advice, others make inappropriate or distressing comments, while still others avoid bereaved individuals altogether. Grieving individuals may be particularly hurt when friends and family do not acknowledge their losses or offer support in their times of need. In terms of spiritual impacts, it is very common for bereaved individuals to turn to religious and faith-based belief systems to help understand or provide a larger context for their losses, while grief may cause others to question their spiritual worldviews or beliefs.

References: Evans, 1997; Jeffreys, 2005; Worden, 2002

**Figure A6: Grief Theories and Models**

**Narrative for Figure A6: Grief Theories and Models**

The next learning point examines theories and models related to how individuals experience and resolve grief. The five-stages of loss model (denial, anger, bargaining, depression, acceptance) created by Elizabeth Kübler-Ross may be the best-known framework for conceptualizing grief in American culture. However, the Kübler-Ross model is based on normative presentations of grief and fails to address the complications that can be associated with the bereavement process.

Most grief models are based on the notion that bereaved individuals experience some type of dysfunction as part of their grief experiences. For example, Freud believed that some individuals experience grief complications that mimic modern-day depressive disorders. He also believed that attachment bonds are an important component of bereavement, and that individuals need to redirect the energy from lost relational bonds into new relational attachments. Based on Freud's premise that resolving grief requires effort, models offered by Lindemann, Parkes and Weiss, and Worden, all conceptualize grief as a series of tasks that bereaved individuals need to complete. In addition to stage and task models, other grief theorists have developed models that frame grief resolution in terms of processes, such as the dual-process model, the continuing bonds model, and the personal narratives model.

References: American Psychiatric Association, 2013; Doughty, Wissel, & Glorfield, 2011; Gross, 2016; Humphrey & Zimpfer, 2008; Jeffreys, 2005; Konigsberg, 2011; Kübler-Ross, 1973; Love, 2007; Neimeyer, 2001; Pomeroy & Garcia, 2009; Ströbe & Schut, 2001; Worden, 2002

Figure A7: Phase Model vs. Task Model

Phase Model vs. Task Model	
<u>4-Phases of Grief (Bowlby)</u>	<u>4-Tasks of Grief (Worden)</u>
Phase 1: Numbing	Task 1: Accept the reality of the loss
Phase 2: Yearning and Searching	Task 2: Work through the pain of the grief
Phase 3: Disorganization and Despair	Task 3: Adjust to an environment without the deceased
Phase 4: Reorganization	Task 4: Develop a way to experience a continuing bond with the deceased



**Narrative for Figure A7: Phase Model vs. Task Model**

Like Freud, Bowlby believed that attachment bonds influence the bereavement process, but rather than conceptualizing grief as a series of tasks to be completed, Bowlby framed bereavement in terms of a series of experiential phases that individuals progress through in order to resolve their grief issues. Similarly, Worden developed a four-task model of grief resolution inspired in part by Freud's work-based concept of grief and in part by Bowlby's attachment-based model of grief.

References: American Psychiatric Association, 2013; Doughty et al., 2011; Gross, 2016; Humphrey & Zimpfer, 2008; Jeffreys, 2005; Konigsberg, 2011; Kübler-Ross, 1973; Love, 2007; Neimeyer, 2001; Pomeroy & Garcia, 2009; Ströbe & Schut, 2001; Worden, 2002

**Figure A8: Self-Reflection Exercise 2**

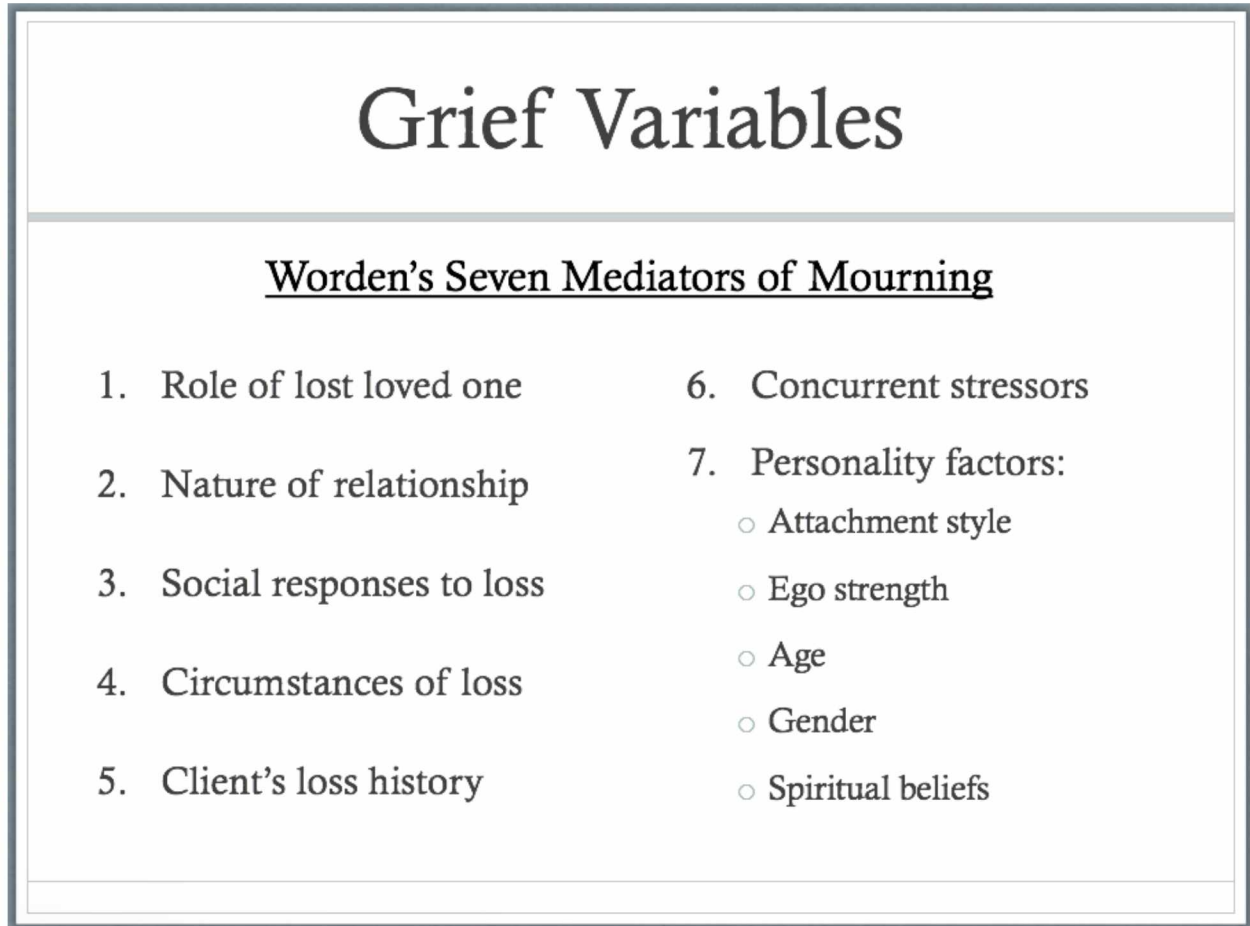
## Self-Reflection Exercise 2

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- How do you think individuals resolve grief?
- What factors influence the grief response?

**Narrative for Figure A8: Self-Reflection Exercise 2**

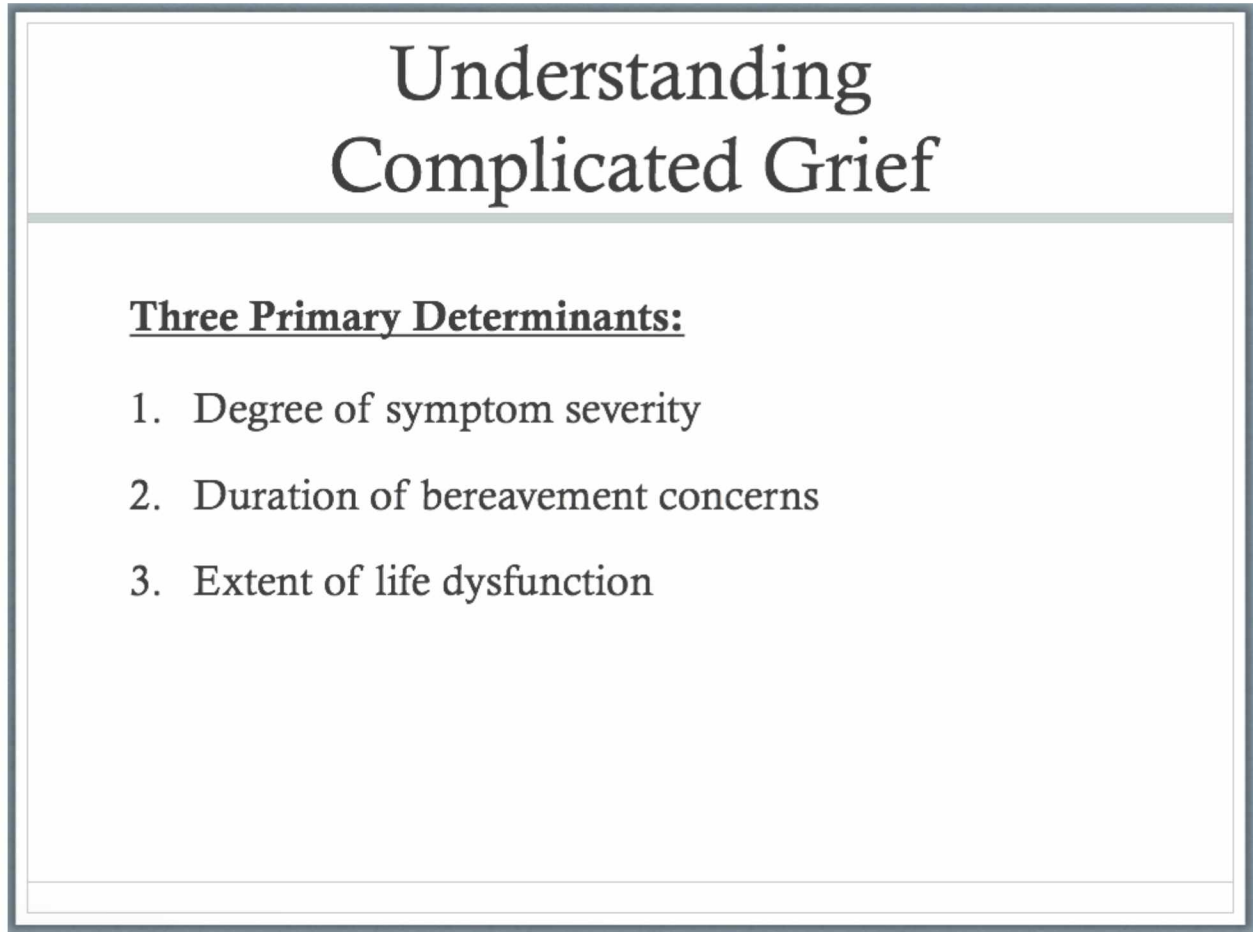
This second self-examination exercise poses the following questions: “How do you think individuals resolve grief?” and “What factors influence the grief process?”. As you think about these questions, try to remember a significant loss from your own life. What in particular made the loss feel significant to you? How long did it take to feel a sense of resolution with your loss? What helped? What did not? The following slide presents Worden’s perspective about the key variables that influence grief reactions.

**Figure A9: Grief Variables**

**Narrative for Figure A9: Grief Variables**

In addition to his task-based bereavement model, Worden's mediators of mourning framework identified seven essential factors that influence grief responses and the overall grief resolution process. Clinicians can use this model as a guide for collecting key assessment data.

References: American Psychiatric Association, 2013; Butler & Degraff, 1996; Hooyman & Kramer, 2006; Houben, 2012; Jeffreys, 2005; Parkes, 2013; Worden, 2002

**Figure A10: Understanding Complicated Grief**

**Narrative for Figure A10: Understanding Complicated Grief**

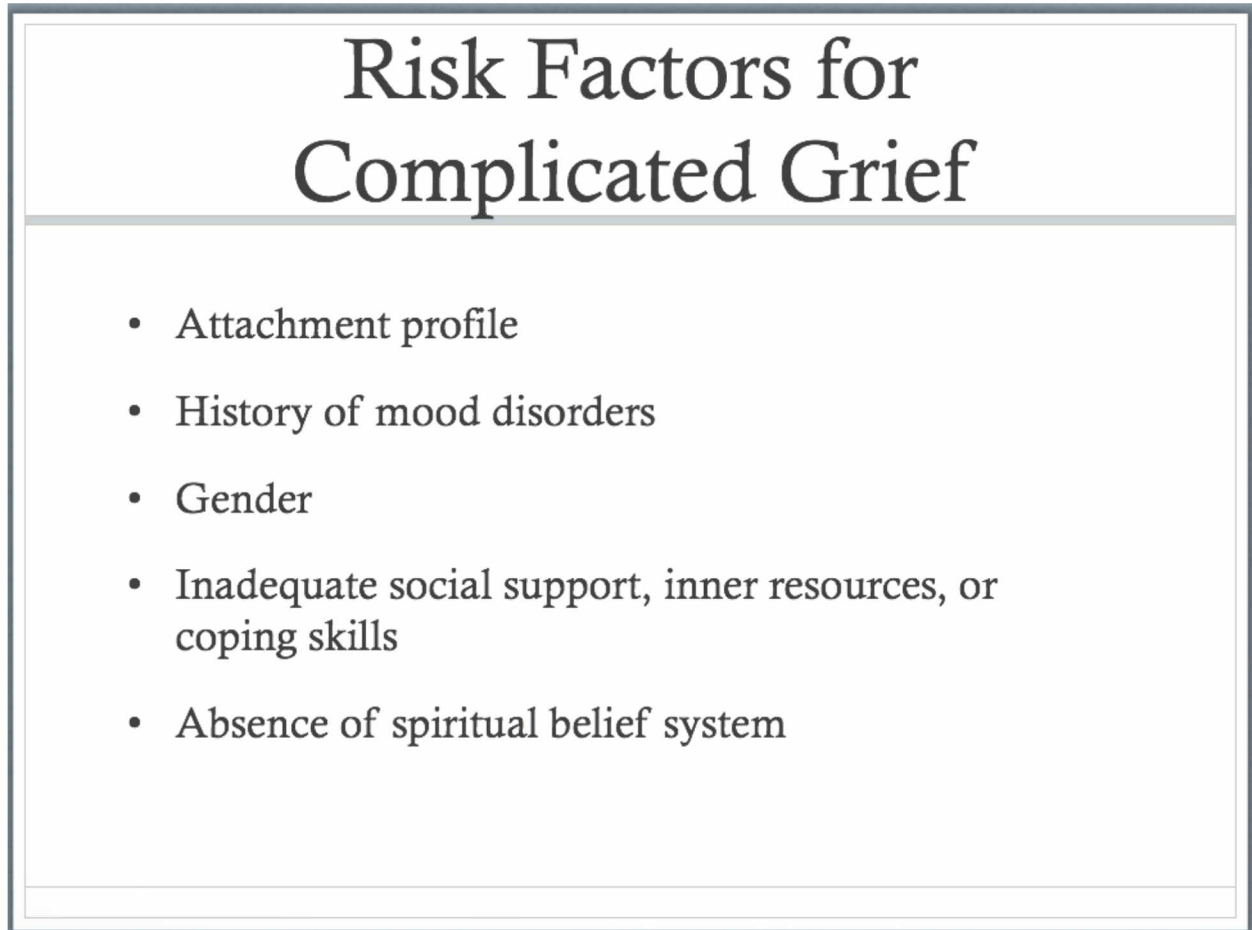
Because 10- to 20% of bereaved individuals experience some form of complicated grief, clinicians need to be able to differentiate between uncomplicated (or normative) grief responses and complicated (or pathological) ones. The three most significant determinants of complicated grief are the degree of symptom severity, the duration of bereavement concerns, and the extent of associated life dysfunction.

When considering the degree of symptom severity, clinicians should note symptoms including intense, persistent distressing thoughts, suicidal or homicidal ideation, and intense feelings of dissatisfaction, hopelessness, emptiness, or regret. Other symptoms associated with complicated grief include a tendency to feel socially isolated, a severe lack of self-care, and a diminished motivation to engage in essential life tasks.

In terms of duration, uncomplicated grief reactions typically resolve within six months. Grief resolution means that individuals are once again able to participate in work tasks, experience pleasure and happiness, and imagine developing new social relationships. Complicated grief reactions are likely to persist beyond this 6-month time frame, and they may persist up to a year or longer.

The extent of dysfunction is an important consideration when grief concurrently impacts multiple life areas, such as home, family, work, and community. When clients are unable, on an ongoing basis, to return to an approximate level of pre-loss functioning in any of these essential life areas, complicated grief is implicated.

References: Hensley, 2006; Jeffreys, 2005; Love, 2007; Neimeyer & Currier, 2009; Shear & Mulhare, 2008; Shear et al., 2007; Zhang, El-Jawahri, & Prigerson, 2006

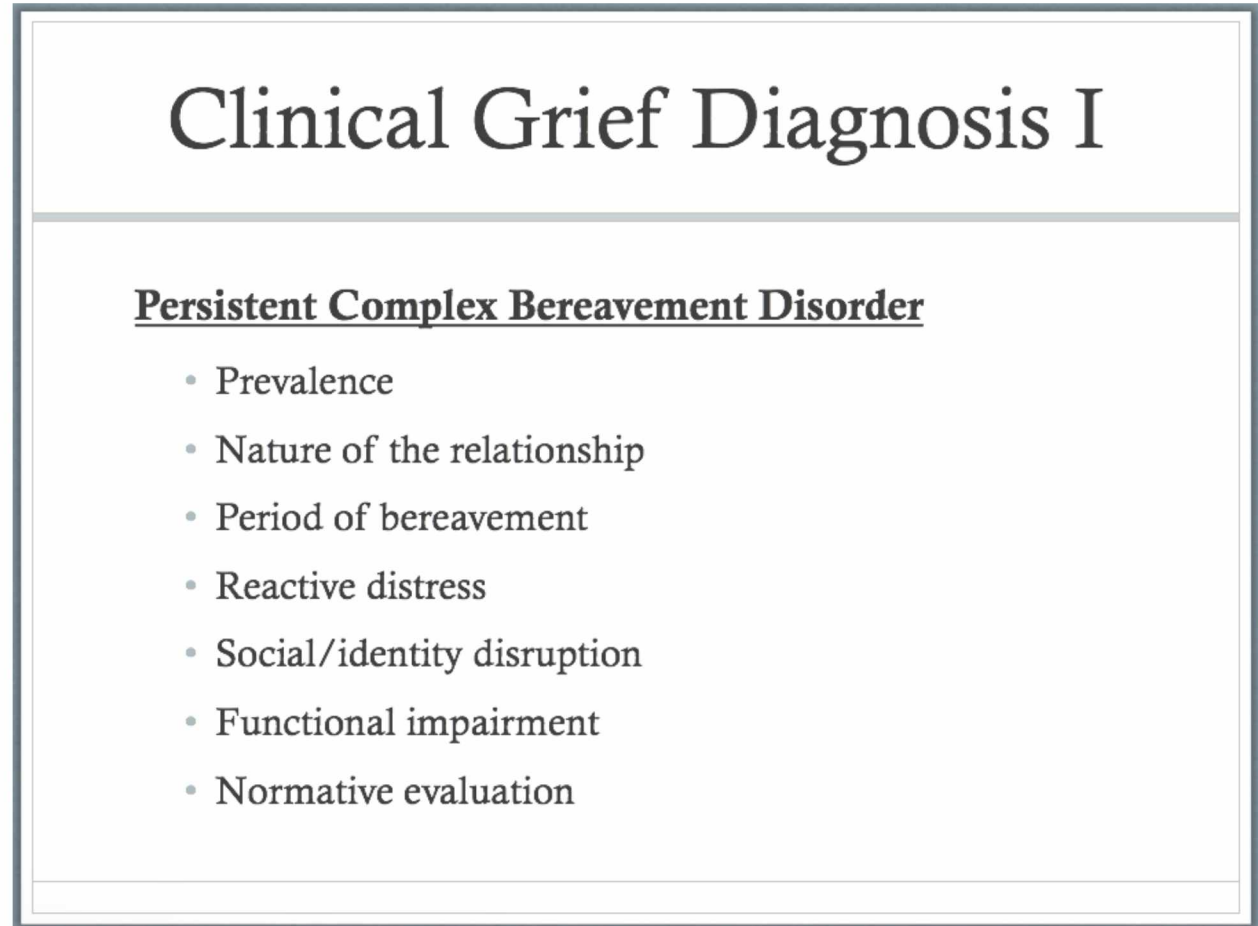
**Figure A11: Risk Factors for Complicated Grief**



**Narrative for Figure A11: Risk Factors for Complicated Grief**

A number of additional factors can place individuals at risk for complicated grief responses. For example, individuals who shared significant attachment bonds with their deceased loved ones may be more vulnerable to complicated grief, particularly if they are unable or unwilling to accept their losses or to revise and update their former attachments. Other risk factors include having a prior history of mood disorders, being female, having inadequate social support, possessing insufficient inner resources or coping skills, and the lack of a spiritual belief system.

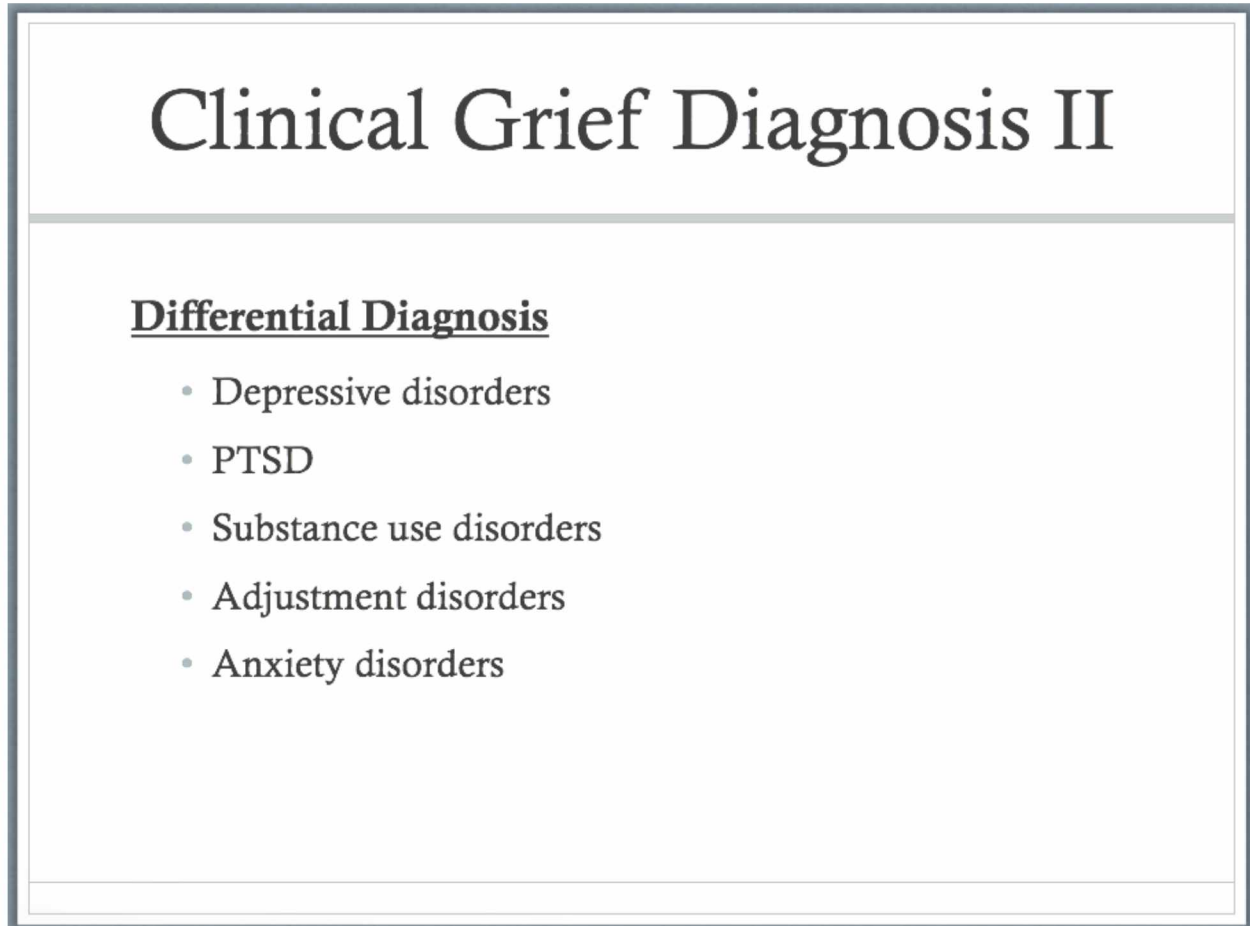
References: Chiu et al., 2010; Hensley, 2006; Jeffreys, 2005; Love, 2007; Neimeyer & Currier, 2009; Shear & Mulhare, 2008; Shear et al., 2007; Zhang et al., 2006

**Figure A12: Clinical Grief Diagnosis I**

**Narrative for Figure A12: Clinical Grief Diagnosis I**

Since its initial inclusion in the DSM-III, the diagnostic consideration of grief has continued to evolve over time. The DSM-V now acknowledges that some grief presentations are characterized by uncomplicated, normative responses while others include complicated, pathological ones. The most recent conceptualization of complicated grief, known as persistent complex bereavement disorder, is featured in the DSM-V as a condition for further study. Although not currently appropriate as a diagnostic construct, the proposed criteria for persistent complex bereavement disorder suggest key factors that should be considered in the assessment of complicated grief.

References: American Psychiatric Association, 1980; American Psychiatric Association, 1994; American Psychiatric Association, 2013; Bandini, 2015

**Figure A13: Clinical Grief Diagnosis II**

**Narrative for Figure A13: Clinical Grief Diagnosis II**

Complicated grief responses often share key characteristics with a number of identified mental health disorders and clinicians may need to use differential diagnosis to appropriately interpret complicated grief symptoms. Substance use disorders, PTSD, and major depressive disorder are the most common comorbid diagnoses with complicated grief and share many of the same symptoms including negative somatic and emotional impacts, impaired cognitive functioning, and suicidal ideation. However, there are also notable differences between grief and other mental health disorders. For example, grief is primarily characterized by feelings of loss and emptiness, which often occur as waves of feeling and typically decrease over time. In contrast, the symptoms of a major depressive episode include a persistent, depressed affect with unrelenting feelings of misery, hopelessness, and worthlessness, as well as pessimistic and self-critical thoughts.

References: American Psychiatric Association, 1980; American Psychiatric Association, 1994; American Psychiatric Association, 2013; Bandini, 2015

**Figure A14: Assessment Instruments**

Assessment Instruments	
<b><u>Grief Variables:</u></b>	<b><u>Attachment:</u></b>
<ul style="list-style-type: none"><li>• Texas Revised Inventory of Grief</li><li>• Core Bereavement Items</li><li>• Hogan Grief Reaction Checklist</li><li>• Grief Evaluation Measure</li></ul>	<ul style="list-style-type: none"><li>• Relationship Questionnaire</li><li>• Adult Attachment Scale</li><li>• Revised Adult Attachment Scale</li></ul>

**Narrative for Figure A14: Assessment Instruments**

Assessment instruments can facilitate the grief assessment process by helping clinicians determine whether clients are at risk for (or currently experiencing) complicated grief responses. For example, the Texas Revised Inventory of Grief provides client data on the progression of the grief process, the Core Bereavement Items provides data on the intensity of grief responses to a recent loss, and the Hogan Grief Reaction Checklist provides data that distinguish normal grief reactions from anxiety or depression. The Grief Evaluation Measure can be used to identify the presence of complicated grief factors and to predict the degree of grief resolution following a year of bereavement.

Clinicians can also use assessment tools to collect information about the attachment bond between the bereaved and the deceased. For example, data from the Relationship Questionnaire can be particularly useful in examining the relationship between adult attachment styles and affective issues, such as anxiety and depression. The Adult Attachment Scale and the Revised Adult Attachment Scale provide data associated with the clients' fears of being unloved or abandoned, as well as their degree of comfort with emotional intimacy, trust, and reliance on others.

References: Altmaier, 2011; Boelen & Prigerson, 2007; Bui et al., 2015; Jordan, Baker, Matteis, Rosenthal, & Ware, 2015; Kominsky & Jordan, 2016; Layman & Swenson, 2013; Ravitz, Maunder, Hunter, Sthankiya, & Lancee, 2010

**Figure A15: Interventions for Uncomplicated Grief**

Interventions for Uncomplicated Grief	
<u>Basic Counseling Skills and Guidelines</u>	<u>Grief Techniques</u>
<ul style="list-style-type: none"><li>• Normalize the experience</li><li>• Provide explicit permission to grieve</li><li>• Be respectful</li><li>• Avoid judgment and clichéd responses</li><li>• Be sensitive to cultural and spiritual traditions</li></ul>	<ul style="list-style-type: none"><li>• Use evocative language</li><li>• Incorporate symbols</li><li>• Process the loss through creative expression</li><li>• Role playing</li><li>• Directed imagery</li></ul>



**Narrative for Figure A15: Interventions for Uncomplicated Grief**

Clients experiencing uncomplicated losses may not need professional interventions, as many uncomplicated grieverers can process their losses by simply relying on their own inner resources and available social supports. However, during the initial two months of mourning, when the experience of grief tends to be the most acute, uncomplicated grieverers may seek professional assistance. Under these circumstances, mental health professionals should engage clients by utilizing basic counseling skills, normalizing the experience for clients, and providing explicit permission for clients to grieve. Overall, clinicians need to be respectful of clients' experiences, avoiding judgment and clichéd responses. A sensitivity to clients' cultural and spiritual grief traditions is also essential.

In addition to building rapport with grieving clients, specific techniques can help facilitate normative grief support. For example, using evocative language can help clients to connect with the reality of the loss and may facilitate the client's access to key emotional material. Using symbols, such as having a client bring in pictures, items of clothing, or other tangible markers of the deceased, can assist the counselor in better understanding the role of the lost loved one in the client's life and the nature of their relationship. Addressing the loss metaphorically can also be particularly beneficial for the client who needs to confront the loss in a less direct and painful way.

References: Haney & Liebsohn, 1998; Jeffreys, 2005; Knight & Gitterman, 2013; McNicholas & Collis, 1995; Worden, 2002

**Figure A16: Self-Reflection Exercise 3**

## Self-Reflection Exercise 3

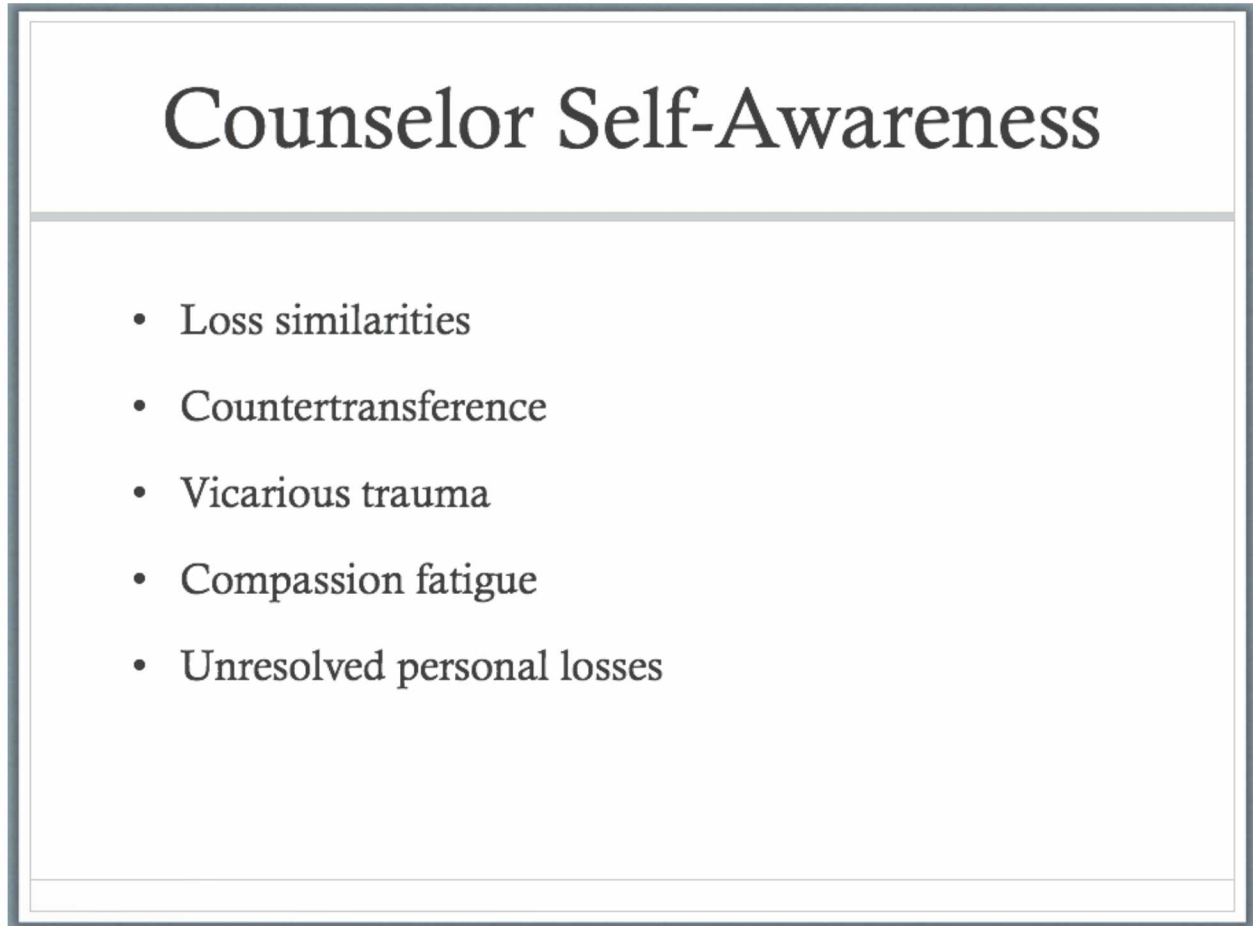
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- What has been your most significant loss?
- What was your relationship to your lost loved one?
- What were the circumstances of the loss?
- What feelings do you remember experiencing?
- How did you cope with this loss?
- How did you know your grief was resolved?

**Narrative for Figure A16: Self-Reflection Exercise 3**

This third self-examination exercise poses a number of questions designed to help clinicians review their own loss histories. After taking some time to reflect on these questions, counselors should be in a better place to empathize with clients' loss experiences, to understand what techniques and interventions might prove most supportive, and to target community and self-help resources.

References: Worden, 2002

**Figure A17: Counselor Self-Awareness**

**Narrative for Figure A17: Counselor Self-Awareness**

Counselors are more likely to feel comfortable discussing issues of loss and grief with clients if they have taken the time to explore their personal thoughts and feelings about death. This need for self-exploration is particularly relevant when clients' losses bear similarities to a loss the clinician has experienced in the past or to a loss they are worried may happen in the future. With this in mind, clinicians should be prepared to acknowledge the presence of counter-transference and to consider and address the possibilities of both vicarious trauma and compassion fatigue. Counselors should also identify avenues for accessing help and support for themselves. If they feel overwhelmed by unresolved personal losses, specifically those that are triggered by clients' experiences, counselors should be prepared to provide a referral to another clinician. Care should be taken as a transfer to a new clinician could be experienced as another loss. If a transfer is likely to occur, it may be best to do so early on before a strong working alliance is formed.

References: Knight & Gitterman, 2013; Pearlman, Wortman, Feuer, Farber, & Rando, 2014; Worden, 2002

**Figure A18: Interventions for Complicated Grief: IPT**

Interventions for Complicated Grief: IPT	
<b><u>Presenting Needs:</u></b>	<b><u>Therapeutic Tasks:</u></b>
<ul style="list-style-type: none"><li>• Maladaptive attachment responses</li><li>• Inadequate social support</li></ul>	<ul style="list-style-type: none"><li>• Build therapeutic alliance</li><li>• Identify dysfunctional communication strategies</li><li>• Modify and practice improved communication strategies</li><li>• Construct social support network</li></ul>

**Narrative for Figure A18: Interventions for Complicated Grief: IPT**

When assessment data indicate a complicated grief reaction, interpersonal therapy (IPT) can be a beneficial intervention strategy. IPT focuses on Bowlby's attachment theory as a means of understanding a client's relational issues, the impact of maladaptive attachment responses, and how these responses create social challenges which may impair an individual's ability to manage interpersonal crises or to generate effective social support networks. IPT assumes that attachment needs may go unmet when social support is inadequate during times of significant distress, and it includes techniques designed to assist individuals with both communicating their needs effectively and developing social networks that feature dependable support. IPT is typically short-term and strengths-based in nature.

Resources: Boelen, 2006; Shear & Mulhare, 2008; Stuart & Robertson, 2012; Wetherell, 2012

**Figure A19: Interventions for Complicated Grief: CBT**

Interventions for Complicated Grief: CBT	
<b><u>Presenting Needs:</u></b>	<b><u>Therapeutic Tasks:</u></b>
<ul style="list-style-type: none"><li>• Inadequate loss integration</li><li>• Dysfunctional thoughts and beliefs about loss</li><li>• Affective avoidance</li></ul>	<ul style="list-style-type: none"><li>• Process and integrate losses using exposure methods</li><li>• Identify and modify faulty loss beliefs and interpretations using cognitive challenges</li><li>• Develop supportive bereavement strategies that engage clients</li></ul>



**Narrative for Figure A19: Interventions for Complicated Grief: CBT**

CBT has been successfully used to address several concerns associated with complicated grief including the need for loss integration, the presence of dysfunctional thoughts and beliefs associated with clients' grief responses, and affective avoidance strategies. CBT attends to these concerns by using exposure methods to help clients process and integrate their losses, presenting cognitive challenges designed to help clients identify and modify dysfunctional interpretations and beliefs, and replacing dysfunctional avoidance strategies with supportive approaches that encourage healthy bereavement adjustments.

Resources: Boelen, 2006; Boelen, van den Hout, & van den Bout, 2006; Shear & Mulhare, 2008; Stuart & Robertson, 2012; Wetherell, 2012

**Figure A20: Self-Reflection Exercise 4**

## Self-Reflection Exercise 4

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- Do you believe that the loss of a pet can impact individuals to the same degree as a human loss?
- How long might you expect clients to grieve the loss of their pets?

**Narrative for Figure A20: Self-Reflection Exercise 4**

This fourth self-examination exercise poses the following questions: “Do you believe that the loss of a pet can impact individuals to the same degree as a human loss?” “How long might you expect clients to grieve the loss of their pets?” “What else would be important for you to know in order to provide support services to bereaved pet owners?” After viewing the information presented in the overview of grief counseling, have your perspectives on grief changed in any way? Please take a moment to consider your answers to these questions before we move on to the next slide and begin our discussion of pet loss counseling.

**Figure A21: Pet Loss Counseling**

**Narrative for Figure A21: Pet Loss Counseling**

Moving forward, this webinar introduces viewers to the topic of pet loss counseling. The elements included in this section of the webinar constitute the core issues identified in the literature as key learning points for mental health professionals counseling bereaved pet owners. After viewing this portion of the webinar, clinicians should be familiar with the substantial impact pets can have in people's lives, three essential factors that influence adult pet loss, the qualities that distinguish complicated pet loss, ways to build the therapeutic relationship with grieving pet owners, and a variety of pet loss interventions.

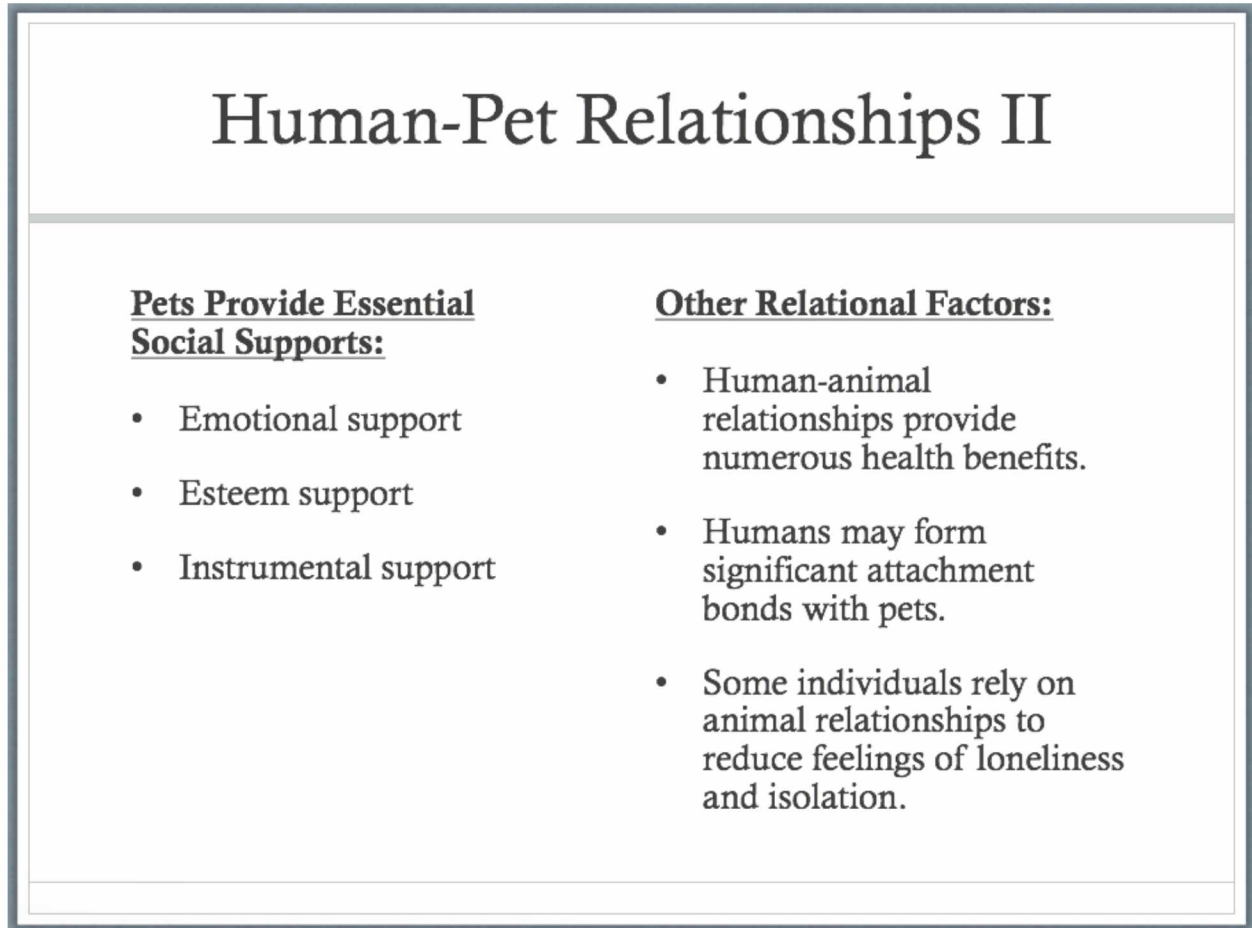
**Figure A22: Human-Pet Relationships I**

Human-Pet Relationships I	
<b><u>Prevalence of Pets:</u></b>	<b><u>Pet Roles:</u></b>
<ul style="list-style-type: none"><li>• More than 50% of U.S. families have pets.</li><li>• 70-90% of pet owners characterize pets as family members.</li><li>• About 40 million Americans experience a new pet loss each year.</li></ul>	<p>Best friend</p> <p>Surrogate child</p> <p>Significant Other</p> <p>Exercise partner</p> <p>Work partner</p> <p>Mobility assistant</p>

**Narrative for Figure A22: Human-Pet Relationships I**

As pets are significant components of many American families, mental health professionals are likely to encounter clients dealing with the loss of a pet at some point in their careers. Although some clinicians may believe that human-pet bonds are inferior to those experienced in interpersonal human relationships, it is critical that clinicians not minimize or pathologize client-pet attachment bonds when counseling bereaved pet owners, as the process of bereavement is a natural response to loss, whether for pet or human losses. The literature indicates that clients are likely to respond to the loss of their pets in a similar manner, and with the same degree of intensity, as they might respond to losing a human member of their families. For some clients, the experience of losing a pet could be among the most significant losses that they experience in their lifetimes.

References: Archer & Winchester, 1994; Beder, 2013; Bobier, 2011; Brown, 2006; Brown, Richards, & Wilson, 2001; Butler & DeGraff, 1996; Clements, Benasutti, & Carmone, 2003; McNicholas & Collis, 1995; Morley & Fook, 2005; Quackenbush & Graveline, 1985; Turner, 2003; Watt-Aldredge, 2005

**Figure A23: Human-Pet Relationships II**



**Narrative for Figure A23: Human-Pet Relationships II**

Many mental health professionals may not fully comprehend the repercussions associated with losing an animal companion. However, in order to better understand the nature of clients' losses, helping professionals need to be familiar with the numerous types of essential relationships that exist between clients and their pets, as well as the supportive functions that animal companions provide.

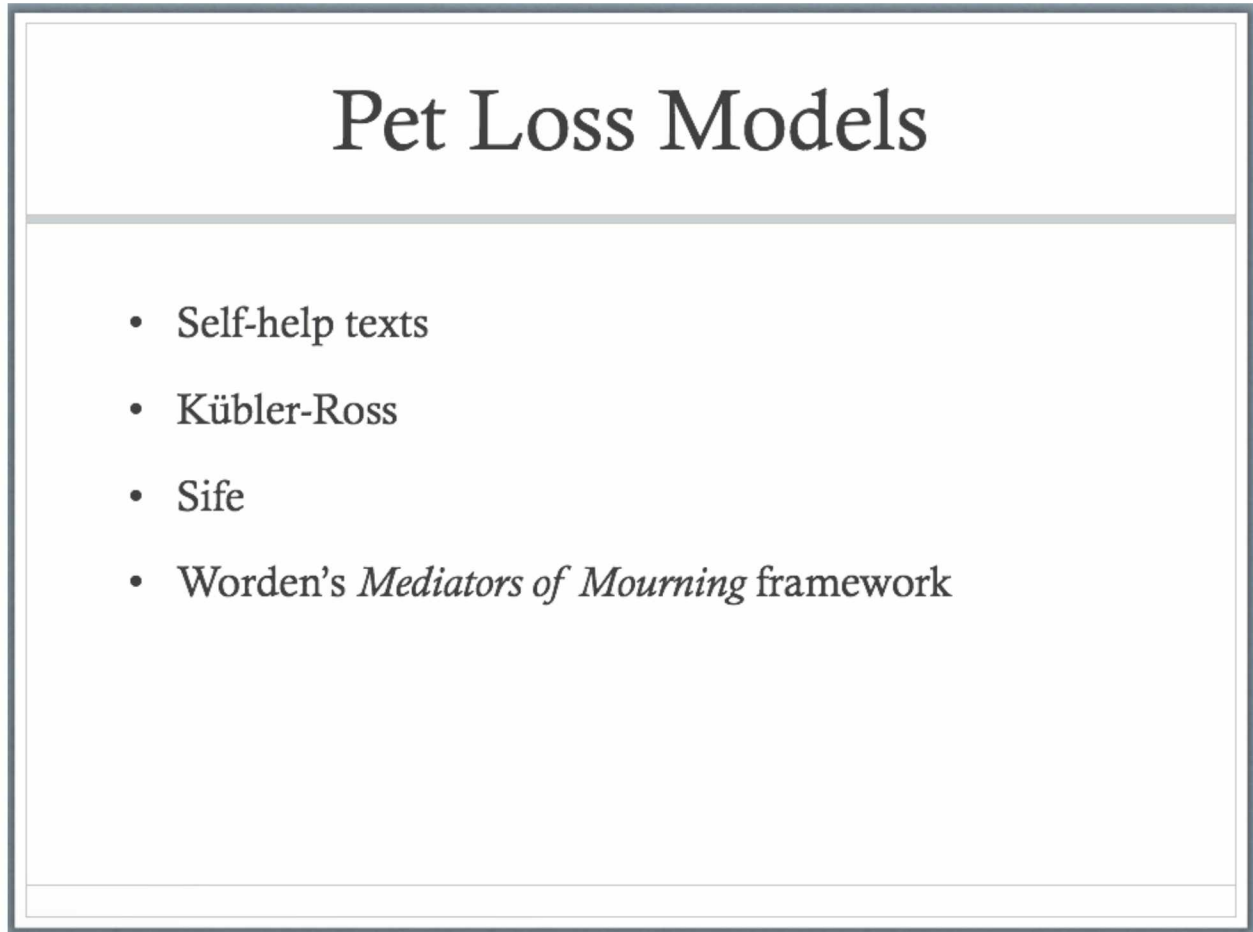
References: Brown, 2006; Gage & Holcolm, 1991

**Figure A24: Components of Pet Loss**

**Narrative for Figure A24: Components of Pet Loss**

Similar to how individuals experience human-human losses, human-pet losses also affect individuals across multiple life domains, including physical, cognitive, emotional, and behavioral. It is important to note that these symptoms are often similar to other mental health concerns or disorders. The physical impacts associated with pet loss may include sleep disturbances, changes in appetite, and increased susceptibility to illness. Cognitive impacts may include a preoccupation with the circumstances of the loss, impaired concentration, repetitive thoughts about the pet, a sense that some part of the self also died along with the pet, and an impulse to search for memory markers of the pet. Emotional impacts may include initial feelings of disbelief or numbness, extended periods of sadness or crying, heightened anxiety, depression, mood swings, and panic attacks. Behavioral impacts may include an increase in obsessive-compulsive and isolating behaviors along with substance abuse. These grief responses may be initially intense, but they tend to diminish over time without professional intervention.

References: Archer & Winchester, 1994; Baier & Buechsel, 2012; McNicholas & Collis, 1995

**Figure A25: Pet Loss Models**

**Narrative for Figure A25: Pet Loss Models**

Although an understanding of general grief models offers clinicians an important empirical foundation, these techniques and interventions must be modified to address specific pet bereavement concerns. In terms of adapting traditional grief models to pet loss, stage and phase models were applied to pet grief in numerous self-help texts. Not surprisingly, given its broad public recognition, the Kübler-Ross model was widely utilized in both the pet loss literature as well as numerous self-help texts about pet loss. One of the most prominent applications of the Kübler-Ross model to pet bereavement can be found in Sife's (2005) book, "*The Loss of a Pet: A Guide to Coping with the Grieving Process When a Pet Dies*," which explicitly adapts the Kübler-Ross model with only minor modifications.

Despite these examples, no single grief model is indicated in the literature as a preferred model for pet loss. Instead, the empirical data collected on the various factors associated with pet grief suggests that Worden's mediators of mourning framework might be most applicable as an adaptive model for identifying the core issues that influence pet loss. Moving forward, the webinar discusses the specific variables associated with pet loss allowing a point-by-point comparison with the Worden framework.

References: Carmack, 2003; Durkin, 2009; Greene & Landis, 2002; Harris, 1996; Nieburg & Fischer, 1996; Quackenbush & Graveline, 1985; Sife, 2005; Turner, 2003; Wolfelt, 2004

**Figure A26: Self-Reflection Exercise 5**

## Self-Reflection Exercise 5

- Given what you have learned so far about pet loss, what would you imagine to be the most significant factors that influence pet grief?

**Narrative for Figure A26: Self-Reflection Exercise 5**

This fifth self-examination exercise poses the following question: “Given what you have learned so far about pet loss, what would you imagine to be the most significant factors that influence pet grief?” Consider what you now know about human-pet relationships, and reflect on how grief impacts individuals in very similar ways for both human and animal losses. Now, please take a moment to consider your answer before we move onto the next slide and discuss the top three factors most likely to influence pet loss reactions.

**Figure A27: Essential Pet Loss Factors**



**Narrative for Figure A27: Essential Pet Loss Factors**

When working with issues of pet loss, mental health professionals must be aware of the three most significant factors that impact individuals' loss responses. These factors include the nature and quality of the human-pet attachment bond, the quality of social support available to the pet owner, and the circumstances of the loss. An understanding of these factors is crucial in the assessment process, as all three have been found to be highly predictive of complicated pet grief.

References: Beder, 2013; Field, Orsini, Gavish, & Packman, 2009; Gosse & Barnes, 1994; McNicholas & Collis, 1995; Wrobel & Dye, 2003

**Figure A28: Self-Reflection Exercise 6**

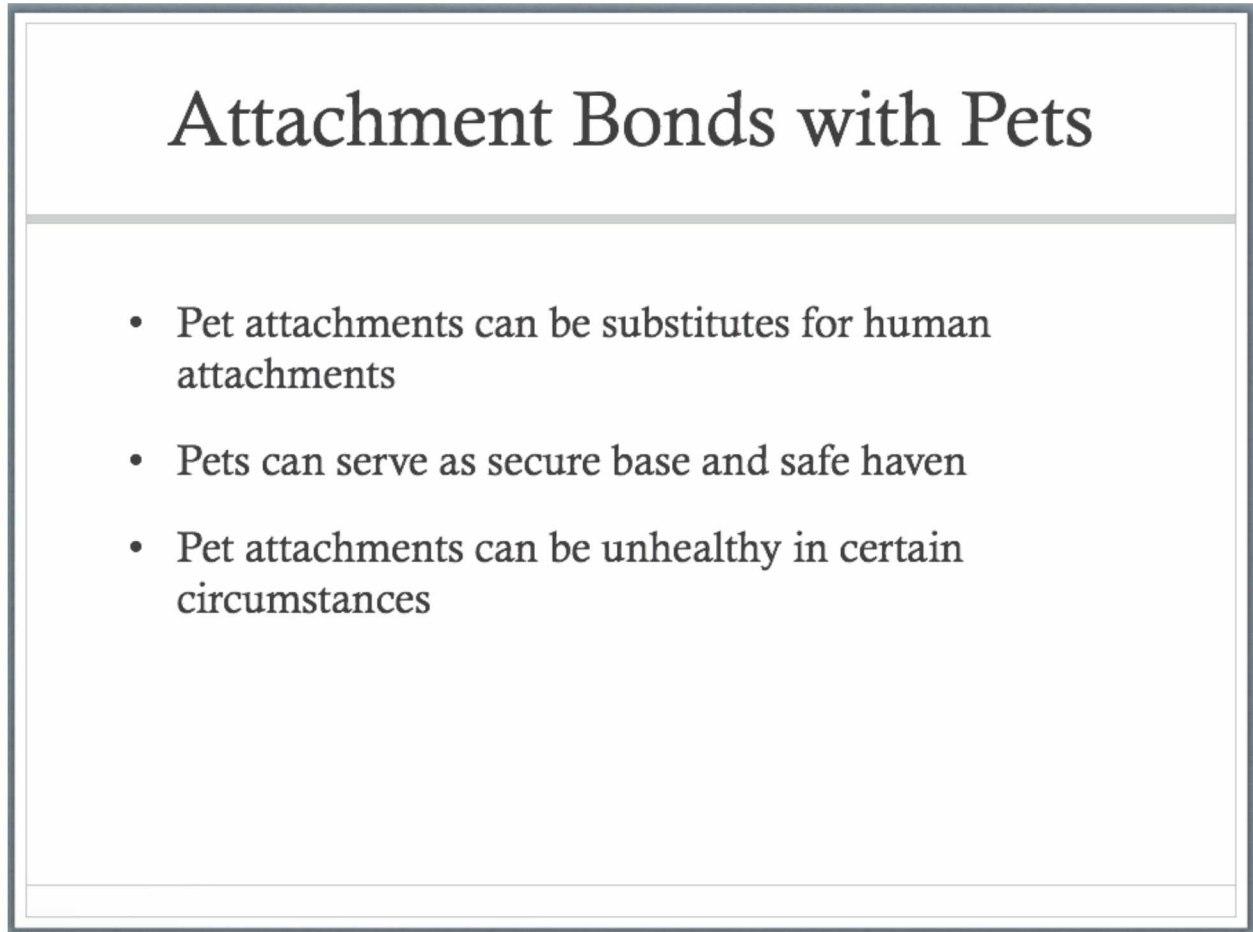
## Self-Reflection Exercise 6

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- How has your attachment style influenced your adult relationships?
- Can you imagine a pet serving as a significant attachment figure in your life?

**Narrative for Figure A28: Self-Reflection Exercise 6**

This sixth self-examination exercise poses the following questions: “How has your attachment style influenced your adult relationships?” “Can you imagine a pet serving as a significant attachment figure in your life?” Consider your primary attachments and social network. Are you the type of person who easily connects to others? Do you have a significant support network that you can rely on in times of distress? Whether or not you have been a pet owner as an adult, can you imagine a pet serving as a surrogate child or primary social companion? In the next slide, we will examine how attachment bonds influence the experience of pet loss.

**Figure A29: Attachment Bonds with Pets**

**Narrative for Figure A29: Attachment Bonds with Pets**

People often form attachment bonds with their pets, and these bonds can be as intense as person-to-person bonds. As a result, these clients may experience severe grief reactions when the bonds with their pets are severed. For some clients, the bonds with their pets provide meaningful substitutes for unhealthy (or absent) person-to-person attachment bonds, and these attachment bonds may feel more significant than any of their other relational connections. For example, women with tendencies to form insecure attachments with other people may find attachments with companion animals particularly compelling, as they offer an experience of security without the fear of abandonment one might experience with a human companion. Similarly, women who do not have children in the home are more likely to establish a mother/child dynamic with a pet and to develop strong relational bonds with their surrogate children.

Attachment functions can also influence the ways in which they relate to their pets. For example, many pets serve as secure bases for their owners. In addition, pet owners with insecure ambivalent attachment styles (and associated relational anxiety) may particularly value the experiences their pets provide as a safe haven, where the simple proximity to their pet promotes feelings of comfort and reduces feelings of stress. Conversely, pet owners with insecure avoidant attachment styles are more likely to perceive pets as unsupportive or unreliable when they don't meet the owners' security needs. Counselors should be also aware that the attachments formed between humans and their pets may sometimes be extremely unhealthy or pathological, particularly when individuals become overly dependent on their pets and use the human-pet relationship as a proxy for more conventional human relationships. When

individuals' emotional needs are primarily fulfilled through their relationships with their pets, complicated grief reactions may occur.

References: Beder, 2013; Brown, 2006; Brown et al., 2001; Carmack, 1991; Chur-Hansen, 2010; Clements et al., 2003; Field et al., 2009; Hawn, 2015; Margolies, 1999; McNicholas & Collis, 1995; Planchon & Templer, 1996; Sable, 2013; Turner, 2001; Zilcha-Mano, Mikulincer, & Shaver, 2012

**Figure A30: Self-Reflection Exercise 7**

## Self-Reflection Exercise 7

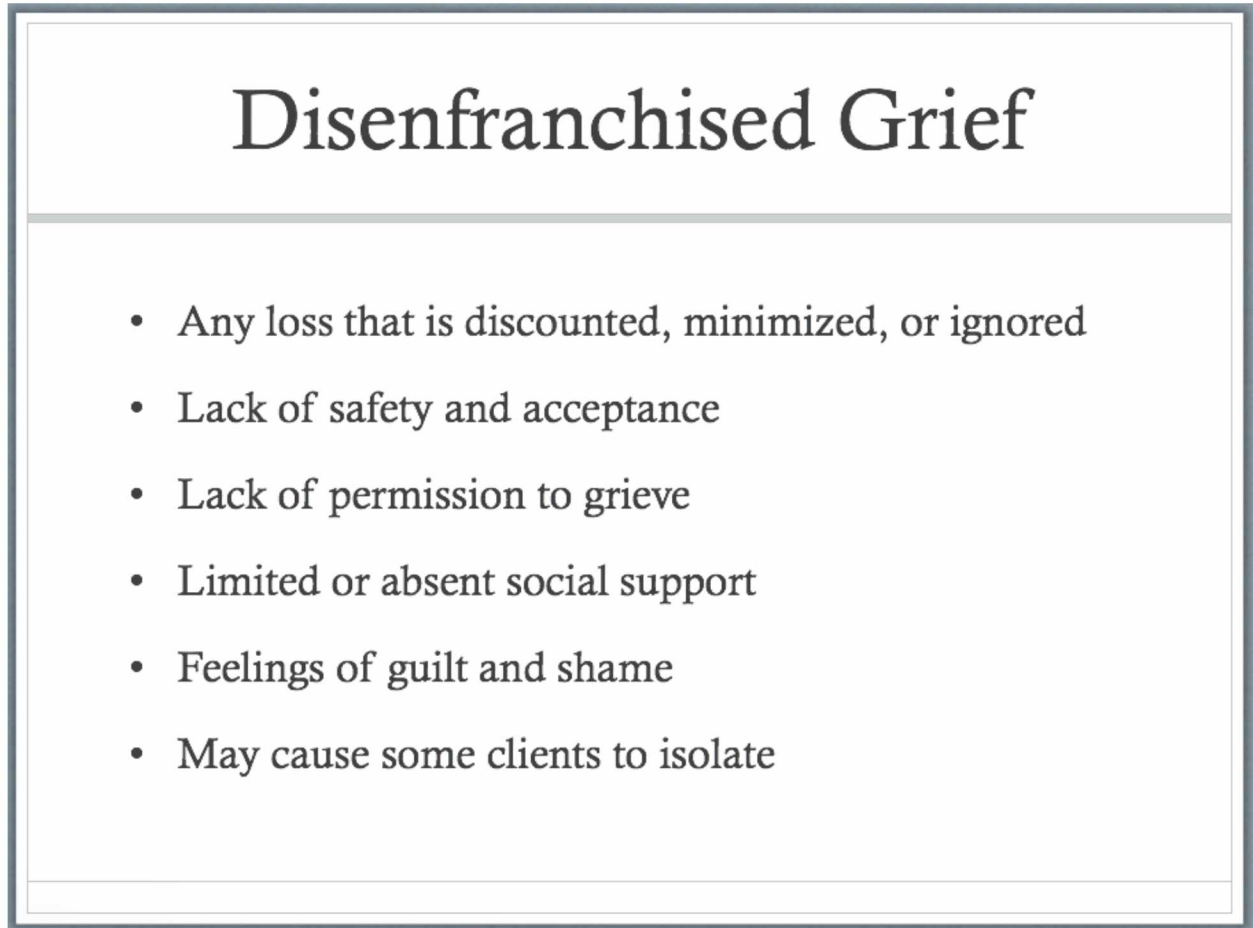
- What kinds of support have been available to you when you have faced significant losses?
- Can you imagine how you would feel if the most important people in your life (family, friends, or colleagues) minimized or dismissed these losses?

**Narrative for Figure A30: Self-Reflection Exercise 7**

This seventh self-examination exercise poses the following questions: “What kinds of support have been available to you when you have faced significant losses? Can you imagine how you would feel if the most important people in your life (family, friends, colleagues) minimized or dismissed these losses?” Please take a moment to consider your answers.

In the next slide, we examine the concept of disenfranchised grief and its role in the experience of pet loss.



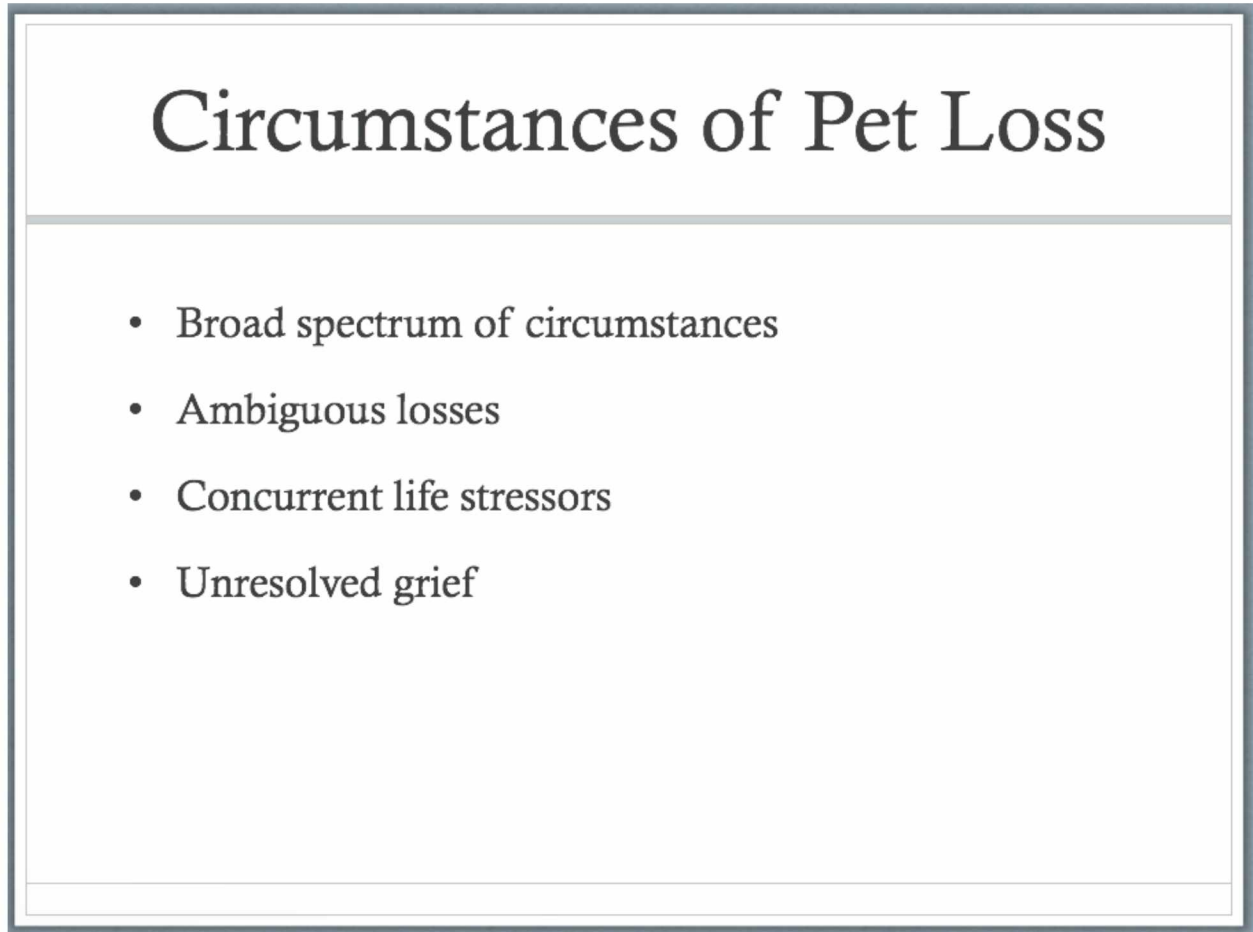
**Figure A31: Disenfranchised Grief**

**Narrative for Figure A31: Disenfranchised Grief**

The importance of understanding the concept of *disenfranchised grief* cannot be overstated, as it is a highly prevalent experience among bereaved pet owners. Disenfranchised grief refers to any loss that is discounted, minimized, or ignored by our society that leads individuals to feel shame about their experiences and a general lack of safety and acceptance in sharing their grief with others. Clients may also experience disenfranchised grief as a lack of permission to grieve the loss of their companion animals in the presence of friends, family, clinical professionals, or veterinary professionals. In terms of timing, our society does not sanction a normal grieving period for pet loss and there is no established timeframe for when it is best to acquire a new pet.

The presence of supportive social relationships in clients' lives is associated with an increased ability to handle substantial life stressors and can act as a protective factor against less significant stressors. However, social support for disenfranchised losses tends to be either limited or absent and individuals often struggle with finding support for pet loss, even among friends, family members, and counselors. This lack of social support seems to be particularly impactful for individuals who live alone, and this population of individuals is at greater risk for more intense grief reactions than those who live with others. Unsympathetic and dismissive responses to individuals' experiences may also exacerbate feelings of guilt and shame, causing clients to isolate from others and ultimately leading to complicated grief responses.

References: Archer & Winchester, 1994; Beder, 2013; Bobier, 2011; Brown et al., 2001; Chur-Hansen, 2010; Cordaro, 2012; Doka, 1989; Durkin, 2009; McNicholas & Collis, 1995; Planchon & Templar, 1996; Quackenbush & Graveline, 1985; Toray, 2004

**Figure A32: Circumstances of Pet Loss**

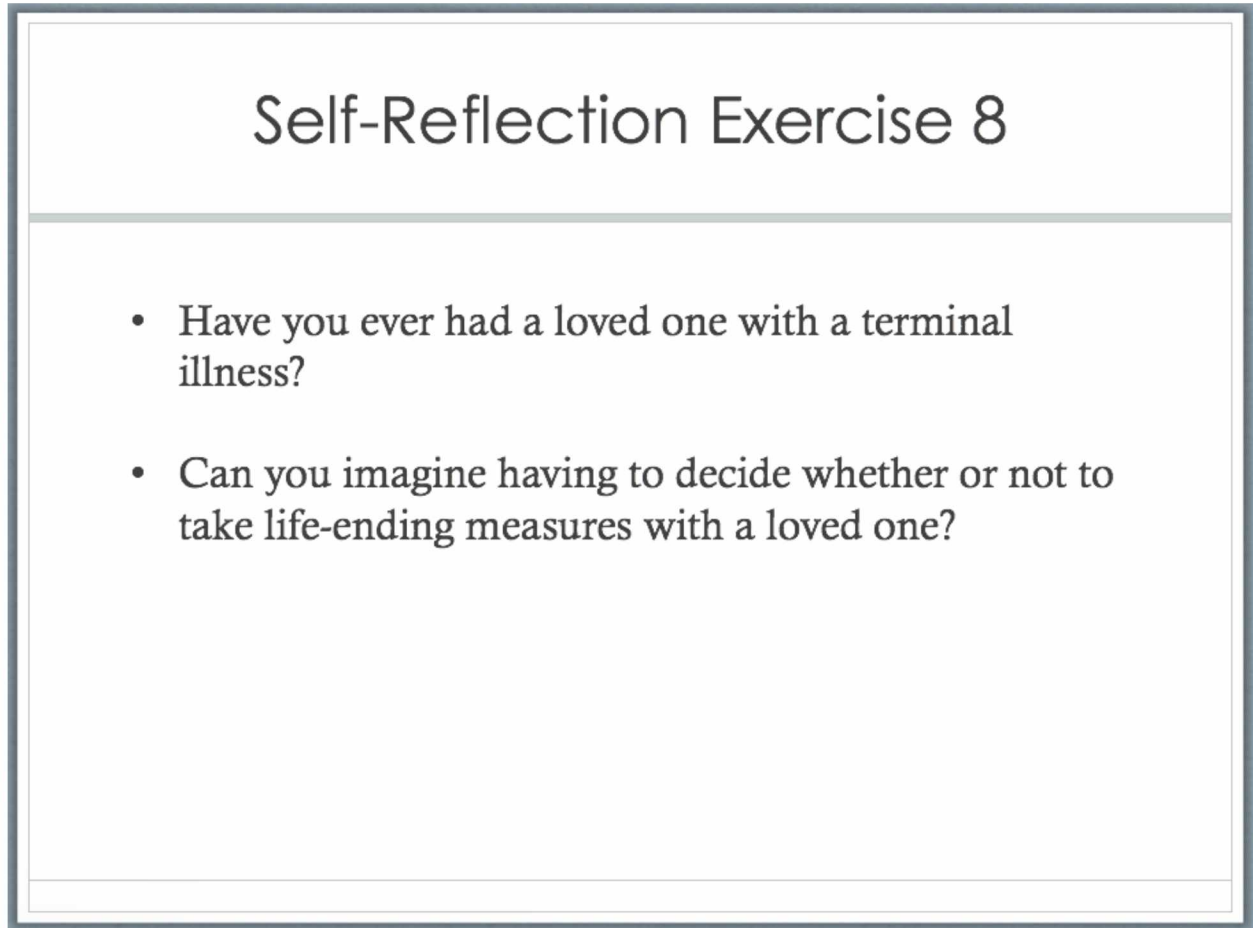
**Narrative for Figure A32: Circumstances of Pet Loss**

The circumstances surrounding the loss of a pet can be one of the most compelling issues associated with pet grief and complicated pet bereavement. When considering the impact of pet loss in clients' lives, it is essential that practitioners have an awareness of the broad spectrum of circumstances associated with pet loss, including natural death, death by accident, death that occurs as the result of a natural disaster, or traumatic death, such as when a pet is purposefully killed or injured. Loss may also occur through disappearance or a change in life circumstances due to poor health, financial difficulties, a change in housing, relationship changes, or theft.

Some losses, such as when a pet goes missing, are never fully resolved; these types of pet losses, known as *ambiguous losses*, are frequently linked to later emotional struggles.

Concurrent losses or stressors may arise when an individual loses a job or can no longer afford to care for the pet, which may lead to aggravated grief responses. Unresolved grief from previous losses may also interfere with the grief integration process.

References: Adrian, Deliramich, & Frueh, 2009; Carmack, 1991; Chur-Hansen, 2010; Clements et al., 2003; Hara, 2007; Humphrey, 2009; Jordan et al., 1984; Lowe, Rhodes, Zwiebach, & Chan, 2009; McCutcheon & Fleming, 2002; McNicholas & Collis, 1995; Sable, 2013; Sife, 2005; Zotarelli, 2010

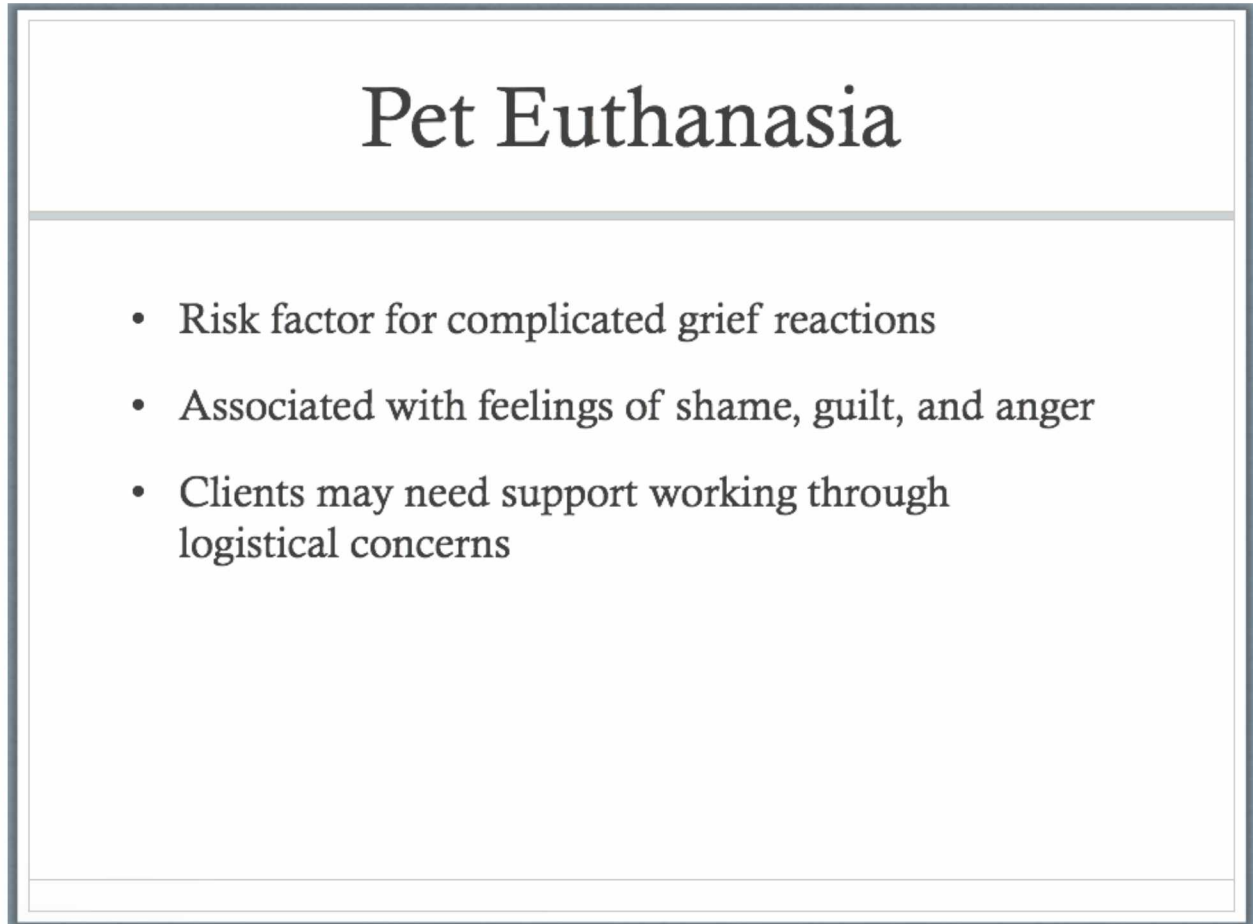
**Figure A33: Self-Reflection Exercise 8**The graphic is a rectangular box with a double-line border. The top section has a light gray background and contains the title "Self-Reflection Exercise 8" in a large, black, sans-serif font. Below this is a horizontal line. The main body of the box has a white background and contains two bullet points in a black, sans-serif font. The first bullet point asks if the reader has ever had a loved one with a terminal illness. The second bullet point asks if the reader can imagine having to decide whether or not to take life-ending measures with a loved one.

## Self-Reflection Exercise 8

- Have you ever had a loved one with a terminal illness?
- Can you imagine having to decide whether or not to take life-ending measures with a loved one?

**Narrative for Figure A33: Self-Reflection Exercise 8**

This eighth self-examination exercise poses the following questions: “Have you ever had a loved one with a terminal illness?” “Can you imagine having to decide whether or not to take life-ending measures with a loved one?” Please take a moment to consider your answers. These are weighty questions that many bereaved pet owners may have dealt with before coming to your office.

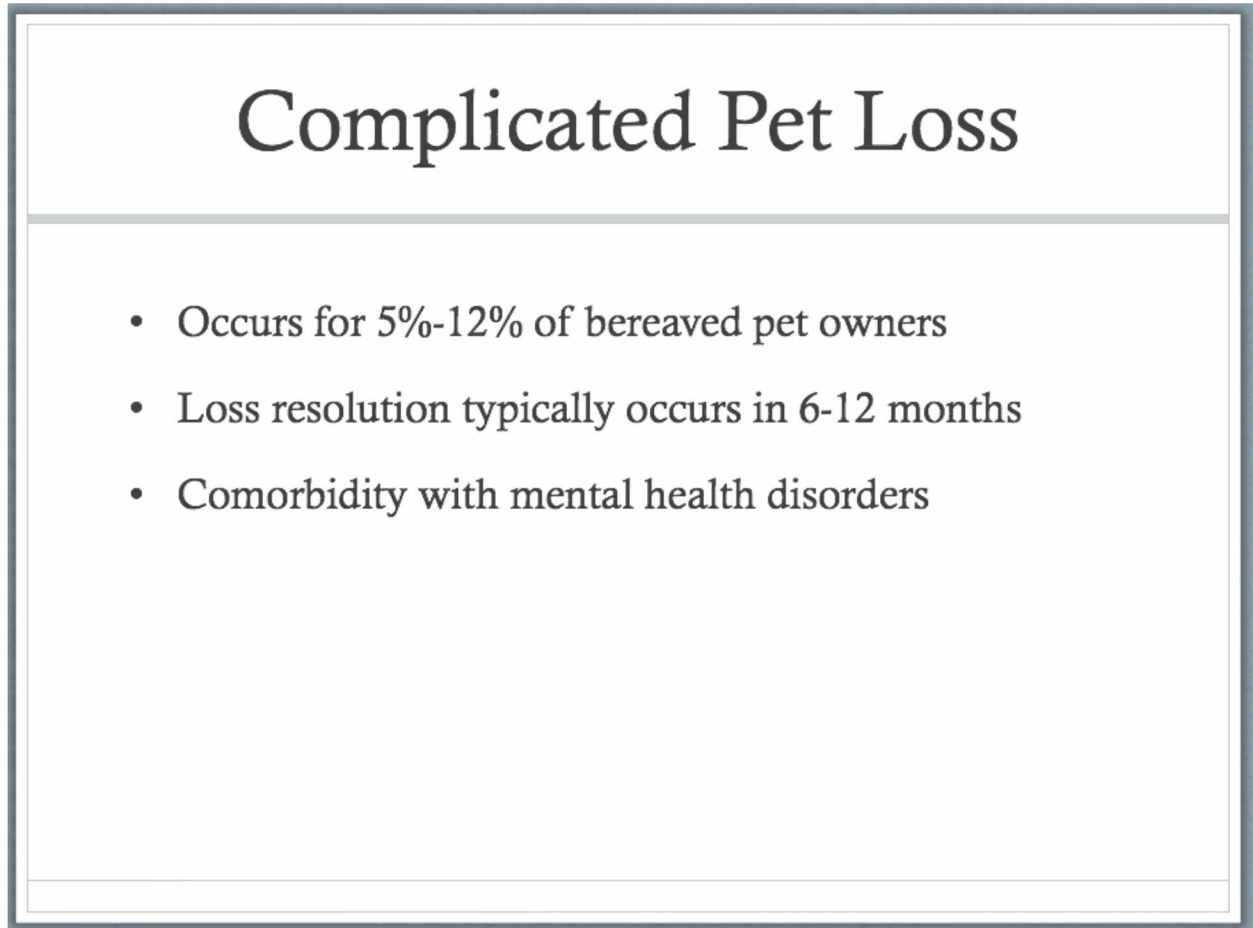
**Figure A34: Pet Euthanasia**

**Narrative for Figure A34: Pet Euthanasia**

Although human bereavement and pet loss share many similarities, the issue of euthanasia is frequently a primary factor in pet loss, as well as a key predictor of complicated pet loss reactions. When euthanasia is part of the circumstances of pet loss, individuals are more likely to experience feelings of anger, guilt, and regret, particularly when financial circumstances were a deciding factor. As such, counselors should be prepared to support clients in making decisions about euthanasia and to help them process the strong feelings of guilt that may accompany the decision to euthanize. In particular, it can be helpful to talk clients through logistical concerns ahead of time, including whether or not they want to be present for the procedure, if they want someone to be with them, and when and where they want the procedure to take place.

References: Chur-Hansen, 2010; Davis, Irwin, Richardson, & O'Brien-Malone, 2003; Durkin, 2009; Fernandez-Mehler, Gloor, Sager, Lewis, & Glaus, 2013; Gosse & Barnes, 1994; Hall et al., 2004; Quackenbush & Graveline, 1985; Turner, 1998



**Figure A35: Complicated Pet Loss**

**Narrative for Figure A35: Complicated Pet Loss**

Although a majority of bereaved pet owners are able to process and resolve their grief experiences without professional facilitation, between 5%-12% experience significant psychological disruptions after the loss of their pets. This figure is notably lower than the nearly 20% of individuals who experience complicated grief following a human loss. The length of time that symptoms persist as well as the severity of the presenting symptoms are key indicators of the degree of grief intensity experienced by individuals. The acute phase of pet loss can persist for up to two months. However, it is not unusual for clients to experience persistent subclinical symptoms of sadness and grief for six months to a year after losing a pet, with 10 months being the average time needed to resolve the loss.

Given the high degree of comorbidity experienced between complicated pet losses and mental health disorders such as depression, anxiety, and PTSD, it is essential that practitioners be careful not to mislabel an expected pet loss reaction as a pathological disorder. Some of the grief reactions associated with complicated pet loss responses include an impulse to search for the lost pet (denial response), debilitating feelings of depression and anxiety, avoiding reminders or thoughts about the loss, and pretending the pet is in the immediate vicinity as a strategy for minimizing feelings of grief.

References: Adrian et al., 2009; Archer & Winchester, 1994; Baier & Buechsel, 2012; Beder, 2013; Hunt & Padilla, 2006; Neimeyer & Currier, 2009; Quackenbush & Graveline, 1985; Wrobel & Dye, 2003

**Figure A36: Risk Factors for Complicated Pet Loss**

**Narrative for Figure A36: Risk Factors for Complicated Pet Loss**

A number of variables can increase an individual's predisposition to complicated pet grief including an absence of family support, a lack of spiritual beliefs, being female versus male, and having a prior history of a mood disorder. Other significant risk factors for complicated pet grief include being elderly, living alone, and assigning human attributes to a pet. When the pet death itself occurs under traumatic conditions, complicated grieving responses are common.

Clinicians should also consider that shorter pet life spans might mean that individuals have experienced multiple pet losses during their lives. For clients who have experienced prior pet losses, it might be beneficial to review what helped them to get through those prior losses in order to rebuild upon those personal strengths. Similarly, it is important to investigate the role of prior non-pet losses, as unresolved grief may be triggered by the loss of a pet, reawakening significant emotional wounds from the past that may serve to further complicate the loss.

Although clients who experience disenfranchised grief and the associated lack of social support are at increased risk for complicated grief responses, individuals who had satisfying relationships, established routines, and adequate levels of social functioning prior to losing their pets are the least likely to experience complicated pet grief. A final predictor of complicated pet grief is the presence of concurrent stressors in clients' lives. Counselors need to understand that the experience of stress is cumulative in nature and individuals who experience concurrent life stressors with their bereavement losses are at an increased risk for anxiety, depression, and stress-based physical responses.

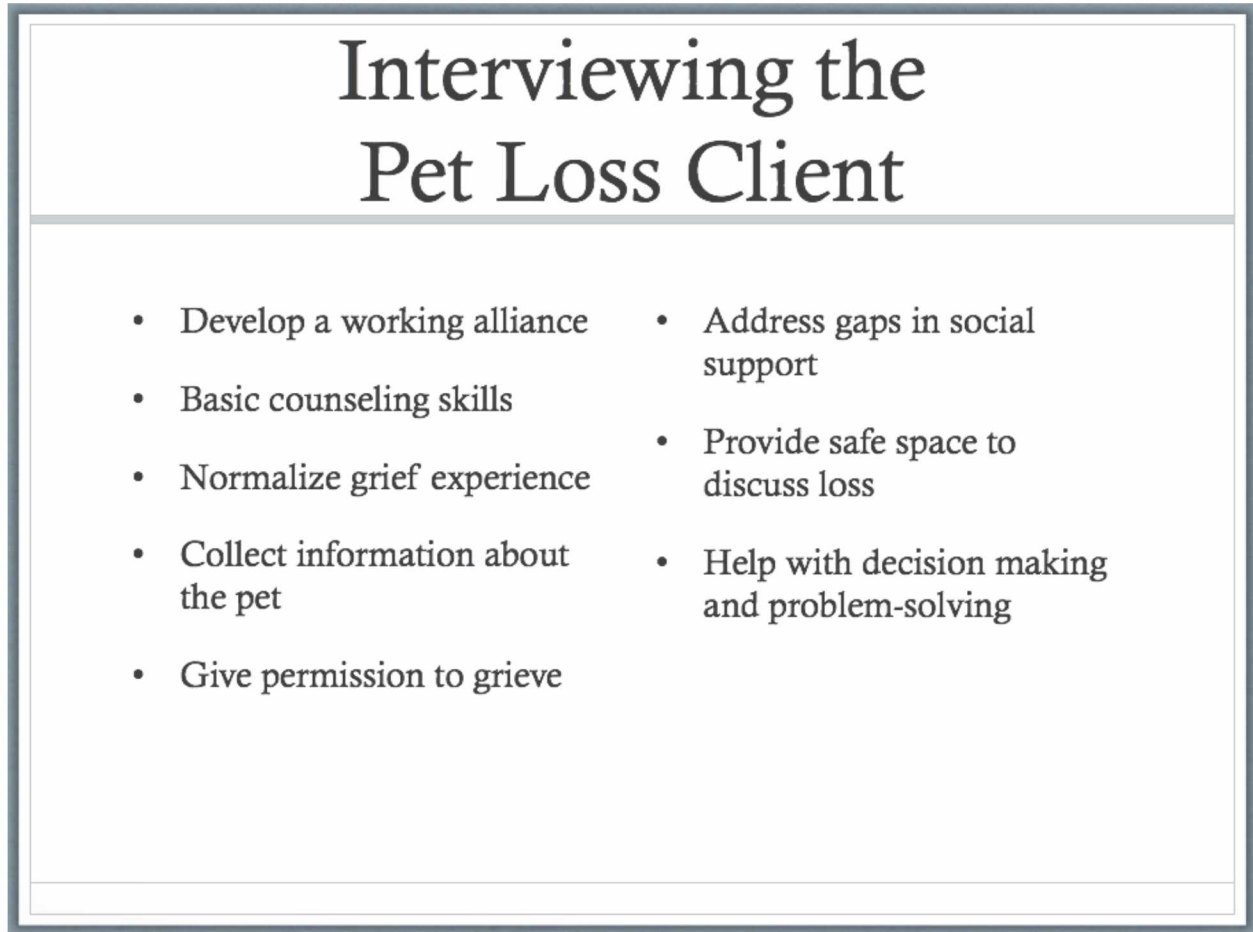
References: Bobier, 2011; Chiu et al., 2010; Chur-Hansen, 2010; Corr, 2004; Donohue, 2005; Fiske, 1995; Heikkinen, 1979; Janssen, 2016; McNicholas & Collis, 1995

**Figure A37: Pet Loss Assessment Instruments**

**Narrative for Figure A37: Pet Loss Assessment Instruments**

Numerous assessment instruments are available to gather data on a variety of pet loss variables. These instruments can supplement assessment data that is collected in initial client interviews. This slide lists several measures that are particularly relevant to pet loss assessment. For example, the Pet Attachment Survey provides information on human-pet attachment bonds, and measures the impact of physical interactions (such as petting) and the degree of emotional intimacy between the owner and their pet. The Dog Attachment Questionnaire provides information on the strength of an individual's attachment bond with their pet and evaluates the degree to which the person relied on the pet as a secure base, invested in a caregiving role with their pet, and anticipated separation anxiety, given the loss of their pet.

References: Archer & Ireland, 2011; Archer & Winchester, 1994; Baucom, 2007; Hunt & Padilla, 2006; Johnson, Garrity, & Stallones, 1992; Wrobel & Dye, 2003; Zasloff, 1996; Zilcha-Mano et al., 2011

**Figure A38: Interviewing the Pet Loss Client**

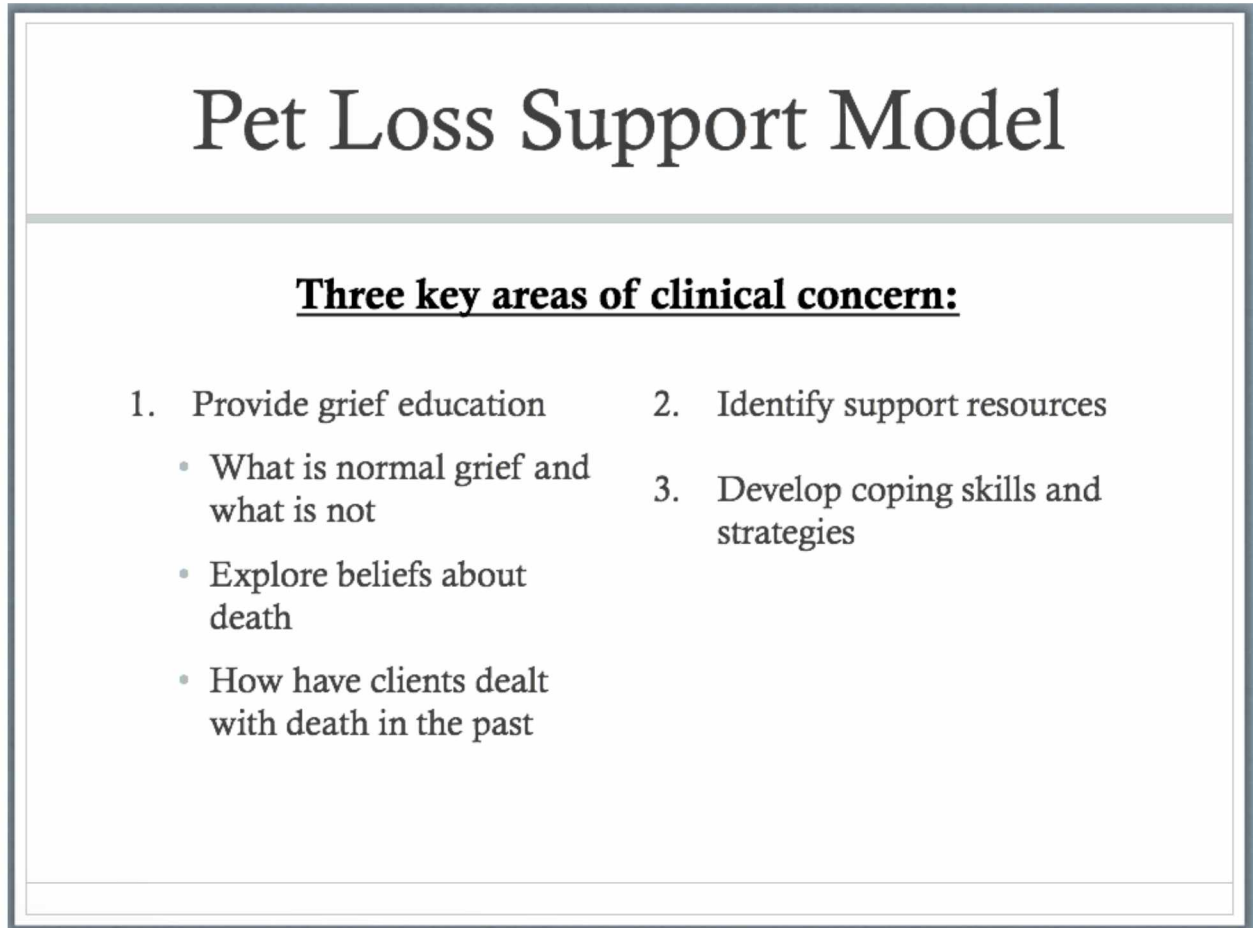
**Narrative for Figure A38: Interviewing the Pet Loss Client**

In developing a working alliance with grieving pet owners, it is essential that counselors engage clients with empathy, sensitivity, and respect. Basic counseling skills, such as reflective listening and empathy, are also important aspects of pet loss support. It is essential for clinicians to normalize any feelings of grief that clients may be experiencing and to educate them about the physical, cognitive, and affective responses that may occur as a normal part of the grieving process.

In initial interviews with bereaved pet owners, counselors should prompt clients to discuss their losses by asking questions about their pets, such as their pet's name, appearance, and the length of time they had their pets. It is also important to have clients share about the nature of their relationship with their pets, the circumstances of their losses, how they felt when their losses occurred, and how their pets shaped their life experiences. Encouraging clients to share photos of their pets and to recount favorite stories can be useful in evoking clients' loss narratives. If clients seem hesitant to discuss their losses, counselors may need to encourage them to talk about their pets and to offer explicit permission for them to express their feelings of grief, particularly if they have felt marginalized by others. The simple process of acknowledging their losses may be particularly meaningful and validating to pet loss clients. In general, all pet loss clients are likely to benefit from clinicians attending to three key issues: (a) providing support to offset the impact of social deficits, (b) providing a safe, receptive space for verbalizing their thoughts and feelings about the loss, and (c) supporting them with decision-making and other necessary problem-solving.

References: Alstat, 1997; Baier & Buechsel, 2012; Beder 2013; Chur-Hansen, 2010; Cicchetti, 2010; Cohen, 2008; Davis et al., 2003; McNicholas & Collis, 1995; Quackenbush & Graveline, 1985; Sable, 1995; Sharkin & Knox, 2003; Turner, 2003

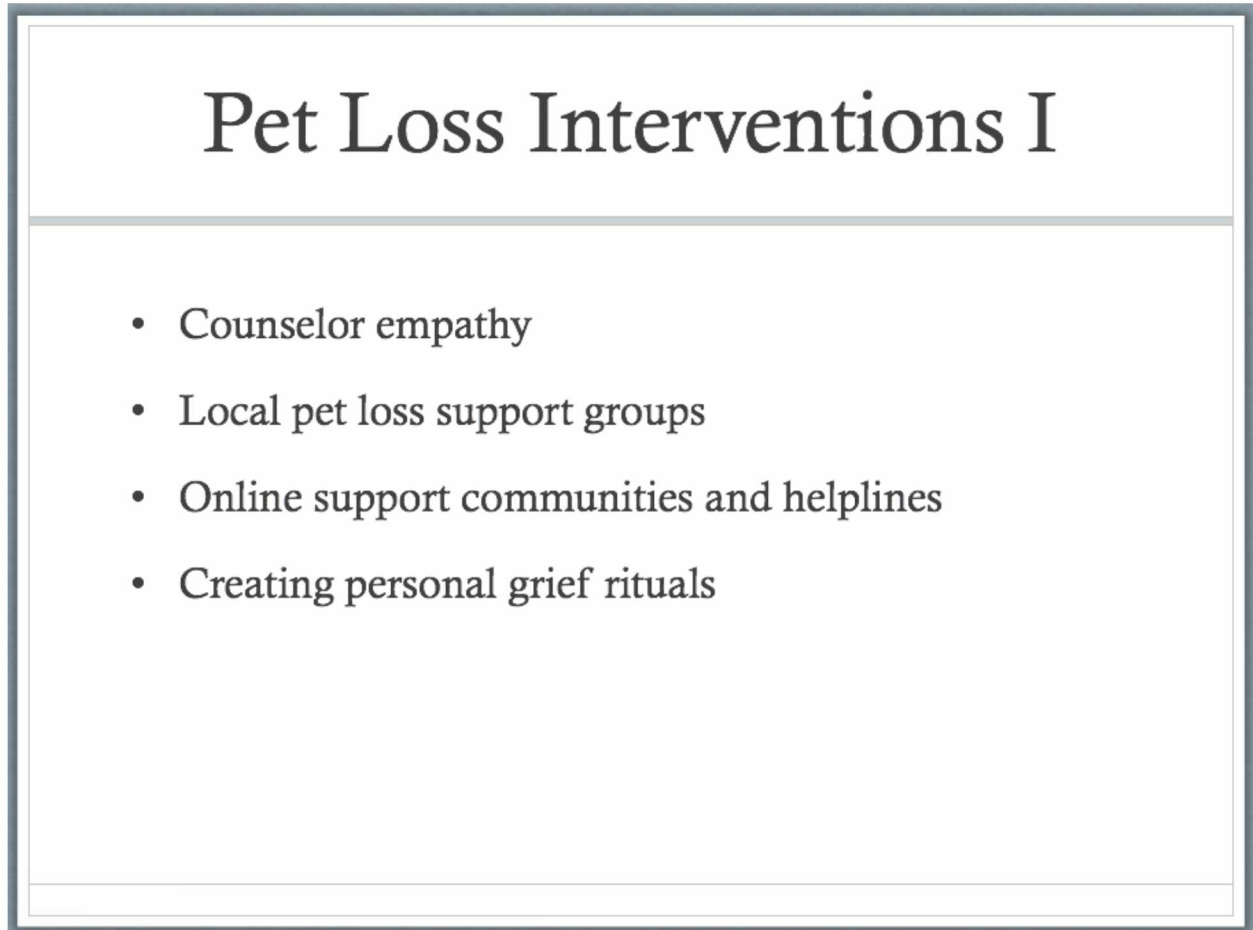


**Figure A39: Pet Loss Support Model**

**Narrative for Figure A39: Pet Loss Support Model**

Although the pet loss literature specifies numerous support strategies for bereaved pet owners, it fails to promote any singular comprehensive model of pet loss support. Instead, the model developed by Quackenbush and Graveline consolidates numerous findings about pet loss into a unified support framework that addresses three key areas of clinical concern. First of all, provide clients with grief education that covers what they can expect to feel during the grieving process, abnormal symptoms of grief, their beliefs about death, and strategies they have used in the past to cope with loss. Second, help clients to identify support resources, including people who are willing to listen to their bereavement narratives and who understand the deep feelings associated with their losses. Finally, support clients in developing effective coping skills and strategies.

Resources: Quackenbush & Graveline, 1985

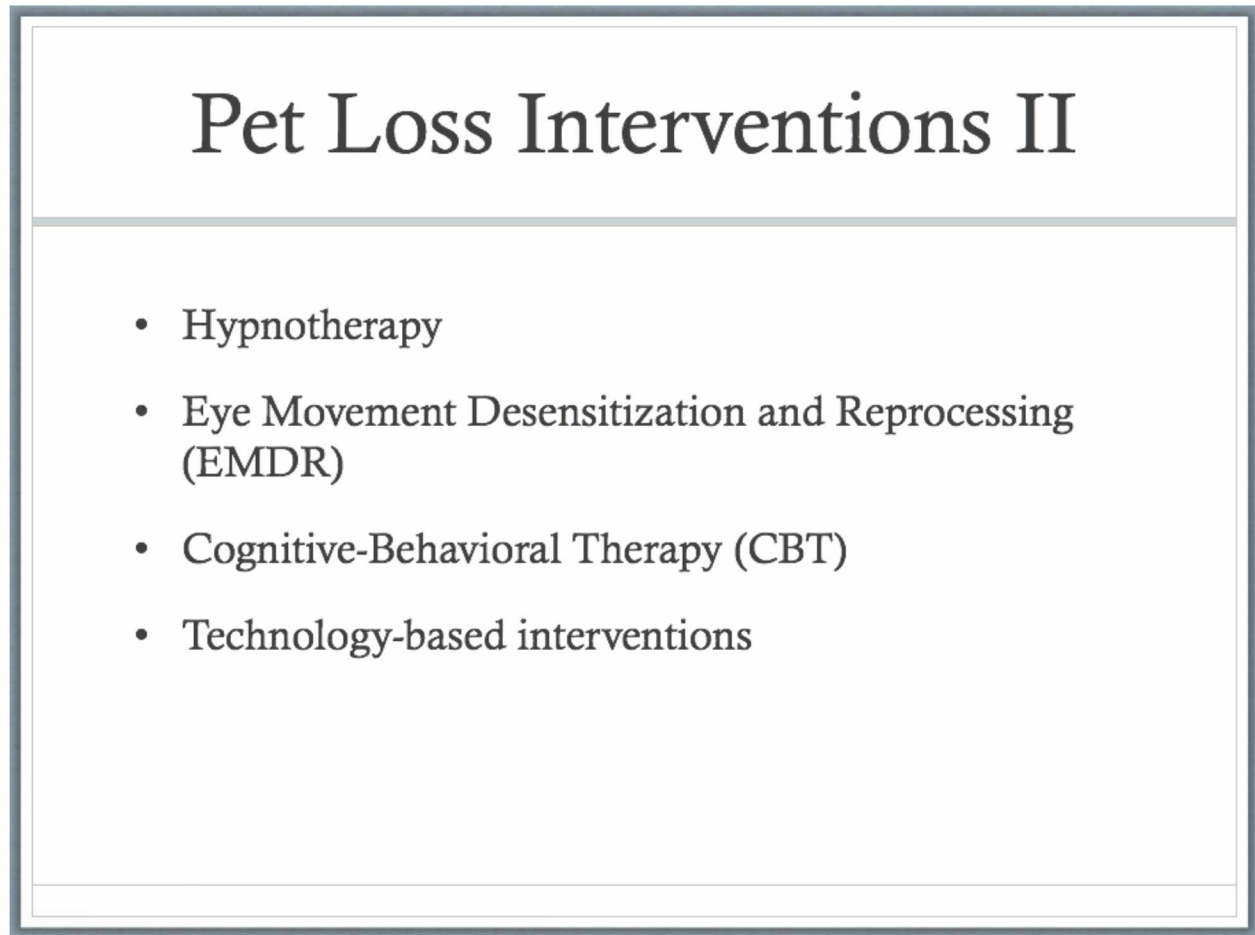
**Figure A40: Pet Loss Interventions I**

**Narrative for Figure A40: Pet Loss Interventions I**

In terms of pet loss interventions, when disenfranchised grief is a factor, counselor empathy can be a significant intervention on its own. In addition, disenfranchised grievers may benefit from pet loss support groups, particularly during the initial, acute phase of grief. Support groups provide several key benefits for disenfranchised grievers: they help normalize and legitimize the experience of pet loss, provide a safe container for individuals to express their feelings, and allow individuals to share their stories and coping strategies. Pet loss groups may also create an opportunity for social bonding between individuals based on their mutual losses and shared understanding. These types of friendships may be particularly beneficial to elderly individuals whose pets served as primary sources of companionship. Similarly, participation in online groups, communities, or helplines may be therapeutic for individuals experiencing disenfranchised loss by providing individuals with feelings of acceptance and a sense of normalcy regarding their bereavement experiences.

When working with bereavement issues, mental health professionals must also be prepared to address clients' religious beliefs and views on spirituality. A familiarity with clients' spiritual beliefs can provide a useful context for helping them to develop rituals for commemorating their pets. Given the lack of specific bereavement rituals socially mandated to acknowledge the loss of pets, creating personalized grief rituals with clients is an intervention that serves to explicitly recognize the passing of their pets and helps clients move towards closure.

References: Beder, 2013; Brown et al., 2001; Carmack, 1991; Dunn, Mehler, & Greenberg, 2005; Evans, 1997; Gage & Holcomb, 1991; McNicholas & Collis, 1995; Packman et al., 2014; Quackenbush & Graveline, 1995; Ross & Baron-Sorensen, 2007; Thurston-Dyer & Hagedorn, 2013; Turner, 2003

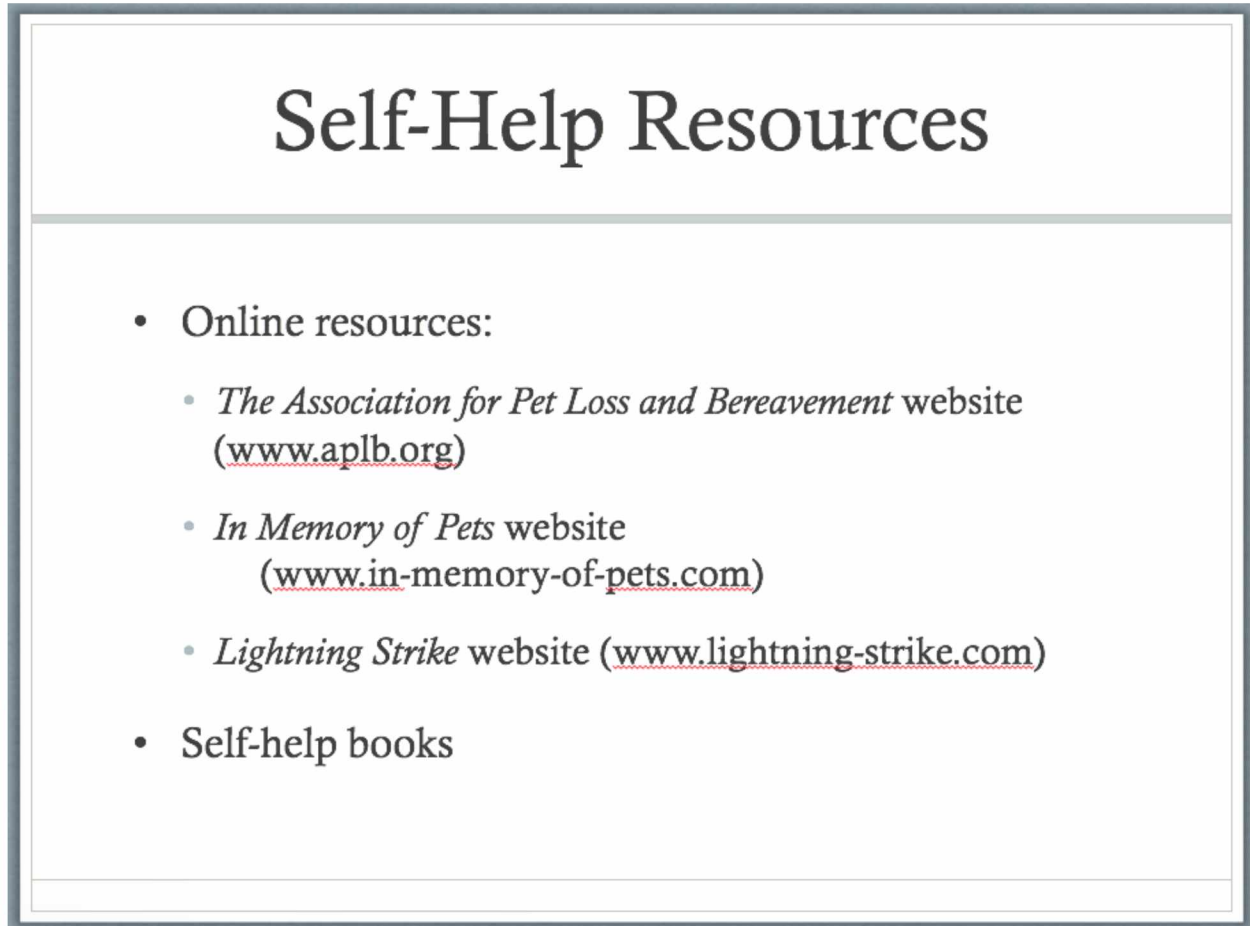
**Figure A41: Pet Loss Interventions II**

**Narrative for Figure A41: Pet Loss Interventions II**

A number of interventions may be particularly helpful for clients who are having more severe pet loss reactions. For example, when pet losses occur under traumatic circumstances, interventions such as hypnotherapy or eye movement desensitization and reprocessing (EMDR) can be beneficial. Cognitive-Behavioral Therapy can be helpful in addressing feelings of anger, guilt, or self-blame that may arise after euthanizing a pet.

For traumatic or other complicated losses, clinicians may also want to consider the use of technology-based interventions that are delivered via the Internet. As an example, a CBT treatment for bereavement administered online via email has proven beneficial in addressing complicated grief reactions associated with PTSD. The treatment, which consisted of a 45-minute writing assignment featuring CBT strategies such as exposure and cognitive restructuring, was completed twice a week and returned to the counselor for feedback via email. This intervention was found to alleviate several key issues associated with complicated grief, such as avoidance, adaptability, and intrusion, and reduced anxious and depressive symptoms.

References: Botella, Osma, Palacios, Guillen & Baños, 2008; Ross & Baron-Sorensen, 2007; Sofka, Cupit, & Gilbert, 2012; Turner, 2003; Wagner, Knaevelsrud, & Maercker, 2006

**Figure A42: Self-Help Resources**

**Narrative for Figure A42: Self-Help Resources**

Connecting clients with self-help resources can be particularly helpful for individuals who need pet loss support but are uncomfortable with more formal interventions such as group work or individual therapy. Online resources that address the needs of bereaved pet owners can be particularly helpful in these circumstances. For example, *The Association for Pet Loss and Bereavement* website offers an extensive variety of support options, including scheduled online chat groups for both pet loss and anticipatory bereavement. Other online resources include the *In Memory of Pets* website which offers ongoing, free pet loss support and the *Lightning Strike* website which offers pet support through live chat and resource referrals.

Clinicians may also want to be familiar with the ways in which pet loss is addressed in the self-help literature, as literature that describes common pet loss responses can reassure clients that their own bereavement responses are neither atypical nor pathological. In order to serve pet loss clients in these ways, clinicians may want to maintain a list self-help resources that includes updated online support sites, books about losing a pet, and other community resources.

References: Cordaro, 2012; Freedman, James, & James, 2014; McNicholas & Collis, 1995; Worden, 2002



**Figure A43: Closings**

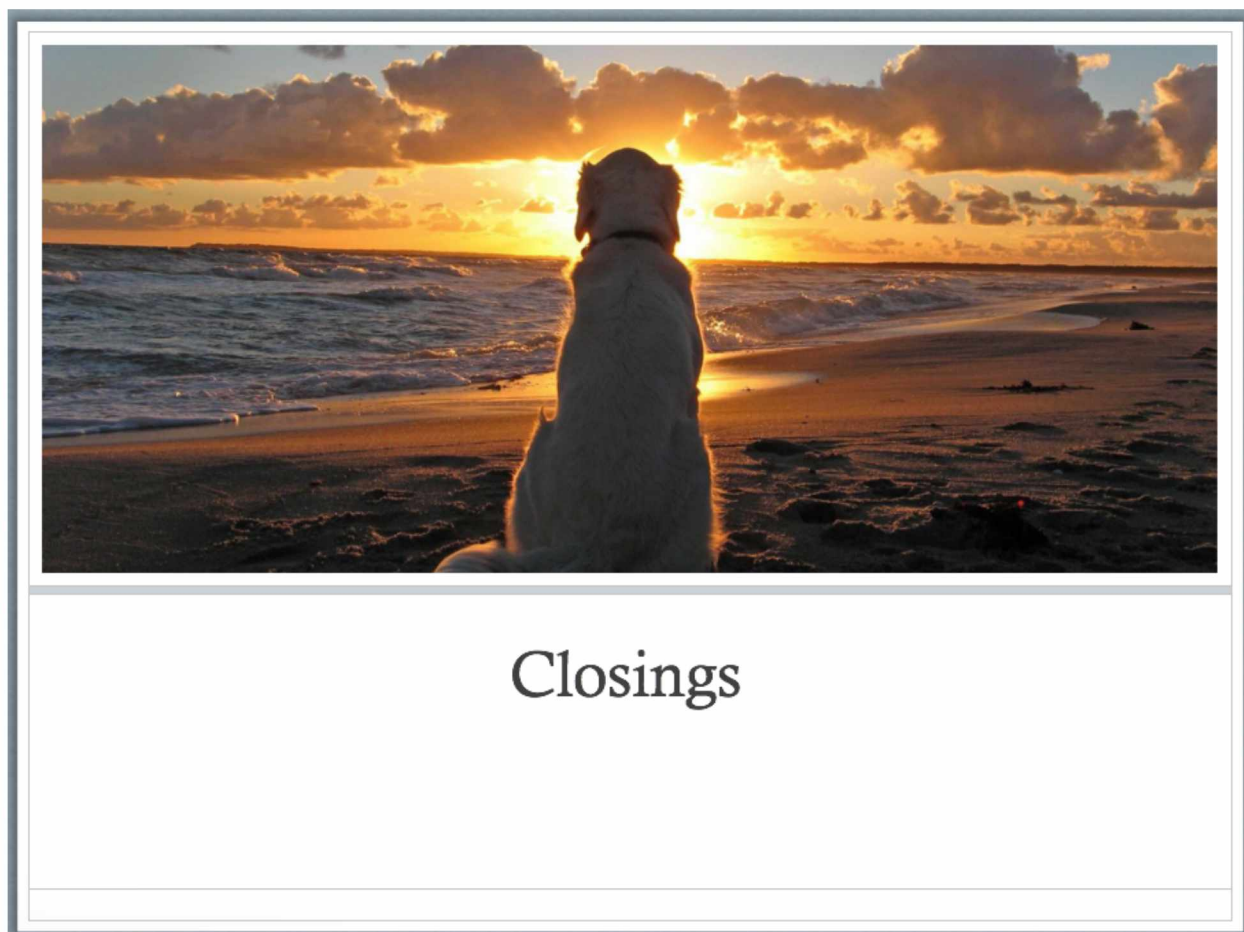


Photo: Suzette Sherman, <http://blog.sevenponds.com/a-right-of-passage/>

**Narrative for Figure A43: Closings**

Beginnings and endings mark some of the most significant moments in our lives. In this webinar, we considered how endings with companion animals impact the lives of pet owners. This presentation was designed to both provide a topical foundation in key issues related to pet loss with adult clients and to increase clinician self-awareness of their own attitudes and judgments on the subject. After viewing this webinar, clinicians should be familiar with the essential issues associated with pet loss and grasp how these issues might inform assessment, diagnosis, and treatment planning. Ultimately, viewers should now understand why pet loss might be a devastating experience for clients and feel better prepared to support clients in ways that lead to optimal healing outcomes.

### **Conclusion**

The educational webinar presented key elements related to grief counseling for adult pet loss. Clinicians who view this webinar should be better prepared to assess and treat adult clients experiencing pet bereavement, whether the loss experience is normative or complicated.

Overall, the webinar, a compilation of information distilled from a comprehensive review of the literature on the subject of adult pet loss, accommodates the identified need for increased educational resources on this topic for mental health professionals.

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## Appendix B

*Diagnostic and Statistical Manual of Mental Disorders (DSM-V) (American Psychiatric Association, 2013)**Proposed Diagnostic Criteria for Persistent Complex Bereavement Disorder*

- A. The individual experienced the death of someone with whom he or she had a close relationship.
- B. Since the death, at least one of the following symptoms is experienced on more days than not and to a significant degree and has persisted for at least 12 months after the death in the case of bereaved adults and 6 months for bereaved children:
  - 1. Persistent yearning/longing for the deceased. In young children, yearning may be expressed in play and behavior, including behaviors that reflect being separated from, and also reuniting with, a caregiver or other attachment figure.
  - 2. Intense sorrow and emotional pain in response to the death.
  - 3. Preoccupation with the deceased.
  - 4. Preoccupation with the circumstances of the death. In children, this preoccupation with the deceased may be expressed through the themes of play and behavior and may extend to preoccupation with possible death of others close to them.
- C. Since the death, at least six of the following symptoms are experienced on more days than not and to a clinically significant degree and have persisted for at least 12 months after the death in the case of bereaved adults and 6 months for bereaved children:

*Reactive distress to the death*

- 1. Marked difficulty accepting the death. In children, this is dependent on the child's capacity to comprehend the meaning and permanence of death.
- 2. Experiencing disbelief or emotional numbness over the loss.
- 3. Difficulty with positive reminiscing about the deceased.
- 4. Bitterness or anger related to the loss.
- 5. Maladaptive appraisals about oneself in relation to the deceased or the death (e.g., self-blame).
- 6. Excessive avoidance of reminders of the loss (e.g., avoidance of individuals, places, or situations associated with the deceased; in children, this may include avoidance of thoughts and feelings regarding the deceased).

*Social/identity disruption*

- 7. A desire to die in order to be with the deceased.
- 8. Difficulty trusting other individuals since the death.
- 9. Feeling alone or detached from other individuals since the death.
- 10. Feeling that life is meaningless or empty without the deceased, or the belief that one cannot function without the deceased.
- 11. Confusion about one's role in life, or a diminished sense of one's identity (e.g., feelings that a part of oneself died with the deceased).
- 12. Difficulty or reluctance to pursue interests since the loss or to plan for the future (e.g., friendships, activities).
- D. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.
- E. The bereavement reaction is out of proportion to or inconsistent with cultural, religious, or age-appropriate norms.

*Specify if: With traumatic bereavement*

Bereavement due to homicide or suicide with persistent distressing preoccupations regarding the traumatic nature of the death (often in response to loss reminders), including the deceased's last moments, degree of suffering and mutilating injury, or the malicious or intentional nature of the death.